Attachment A

"Steelman Launches "BELIEVE" Program to Help Get Foster Kids to College: Bass Pro is First Sponsor," Office of Missouri State Treasurer, Sarah Steelman, December 22, 2005

PRESS RELEASE

Office of Missouri State Treasurer Sarah Steelman

FOR IMMEDIATE RELEASE -- December 22, 2005

Steelman Launches "BELIEVE" Program to Help Get Foster Kids to College: Bass Pro is First Sponsor

SPRINGFIELD Mo. -- Christmas came a few days early for some special Missourians. State Treasurer Sarah Steelman today kicked off a statewide initiative to give crucial help to Missouri's foster children. The project, called BELIEVE, is a partnership between the Treasurer's office and the citizens and organizations of the state to provide college savings accounts for these children – all at no cost to taxpayers.

Steelman, who oversees the state's tax-preferred 529 college savings plan, called MO$T, said the program was a gift for all Missourians.

"There are thousands of precious children in foster care in Missouri today," Steelman said. "They are all special, they all were wondrously created and were given to us for a unique and important purposes. Today we have a new way to help them, to give them a way to fulfill their destinies, and a reason to hope."

Bass Pro Shops appeared with Steelman at the launch, and were announced as BELIEVE's first partners, having selected two foster children to sponsor, and will now work with the Treasurer's office to set up MOST accounts for them.

"We believe in this program, and in the potential it holds for these foster children," Bass Pro spokesman and Outdoor Educator Larry Whiteley said. "That's why Bass Pro Shops is proud to be the first to join this program to help these at-risk foster children."

BELIEVE is an acronym for Bringing Educational Leadership By Investing and Expecting Victory in Every Child, and Steelman says that is just what her program does.

"There is magic inside each of these kids. As a mother, I know that the key to a child's success is belief in themselves.

"For most kids, it's their parent who instills this confidence, but many foster children don't have anyone who believes in them. When they turn 18, most of them have nowhere to go. This is a wonderful way for Missourians to truly make a difference in these children's lives," said Steelman.

Attachment B

Alaska Statute 47.10.090-47.10.093

1 of 1 DOCUMENT

*** CURRENT THRU ALL 2005 LEGISLATION ***
*** ANNOTATIONS CURRENT THRU OPINIONS DECIDED ***
*** AS OF SEPTEMBER 23, 2005 ***

TITLE 47. WELFARE, SOCIAL SERVICES AND INSTITUTIONS
CHAPTER 10. CHILDREN IN NEED OF AID
ARTICLE 1. CHILDREN'S PROCEEDINGS

GO TO CODE ARCHIVE DIRECTORY FOR THIS JURISDICTION

Alaska Stat. § 47.10.090 (2006)

Sec. 47.10.090. Court records

(a) The court shall make and keep records of all cases brought before it.

(b) *[Repealed, § 55 ch 59 SLA 1996.]*

(c) Within 30 days after the date of a child's 18th birthday or, if the court retains jurisdiction of a child past the child's 18th birthday, within 30 days after the date on which the court releases jurisdiction over the child, the court shall order all the court's official records pertaining to that child in a proceeding under this chapter sealed. A person may not use these sealed records unless authorized by order of the court upon a finding of good cause.

(d) The name or picture of a child under the jurisdiction of the court may not be made public in connection with the child's status as a child in need of aid unless authorized by order of the court or unless to implement the permanency plan for a child after all parental rights of custody have been terminated. This subsection does not prohibit the release of aggregate information for statistical or other informational purposes if the identity of any particular person is not revealed by the release.

(e) The court's official records under this chapter may be inspected only with the court's permission and only by persons having a legitimate interest in them. A foster parent is considered to have a legitimate interest in those portions of the court's records relating to a child who is placed by the department with the foster parent or who the department proposes for placement with the foster parent.

HISTORY: (§ 10(3)(4) art I ch 145 SLA 1957; am § 1 ch 124 SLA 1972; am § 1 ch 90 SLA 1975; am § 20 ch 63 SLA 1977; am § 4 ch 130 SLA 1988, am § 56 ch 50 SLA 1989; am § 1 ch 98 SLA 1994; am § 12 ch 113 SLA 1994; am §§ 29 — 31, 55 ch 59 SLA 1996; am § 34 ch 99 SLA 1998; am §§ 18, 19 ch 64 SLA 2005)

NOTES:

CROSS REFERENCES.—For similar provisions related to delinquent minors, see AS 47.12.300.

For effect of the 1998 amendment to subsection (e) on the Alaska Child in Need of Aid Rules, see § 78, ch. 99, SLA 1998 in the 1998 Temporary and Special Acts.

For the text of the amendment of Rule 22(c), Child in Need of Aid Rules of Procedure, setting out a conforming court rule change consistent with the 2005 amendment of (d) of this section, see § 55, ch. 64, SLA 2005, in the 2005 Temporary and Special Acts.

1 of 1 DOCUMENT

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CHAPTER 10. CHILDREN IN NEED OF AID
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Alaska Stat. § 47.10.092 (2006)

Sec. 47.10.092. Disclosure to certain public officials and employees

(a) Notwithstanding AS 47.10.090 and 47.10.093, a parent or legal guardian of a child subject to a proceeding under AS 47.10.005 – 47.10.142 may disclose confidential or privileged information about the child or the child's family, including information that has been lawfully obtained from agency or court files, to the governor, the lieutenant governor, a legislator, the ombudsman appointed under AS 24.55, the attorney general, and the commissioner of health and social services, administration, or public safety, or an employee of these persons, for review or use in their official capacities. The Department of Health and Social Services and the Department of Administration shall disclose additional confidential or privileged information, excluding privileged attorney-client information, and make copies of documents available for inspection about the child or the child's family to these state officials or employees for review or use in their official capacities upon request of the official or employee and submission of satisfactory evidence that a parent or legal guardian of the child has requested the state official's assistance in the case as part of the official's duties. A person to whom disclosure is made under this section may not disclose confidential or privileged information about the child or the child's family to a person not authorized to receive it.

(b) The disclosure right under (a) of this section is in addition to, and not in derogation of, the rights of a parent or legal guardian of a minor.

(c) The obligations under (a) of this section remain in effect throughout the period that the child is in the custody of the department, including after the parent's parental rights have been terminated with respect to the child, unless the child's parent or legal guardian who made the disclosure under (a) of this section subsequently files a notice with the Department of Health and Social Services that the assistance of the state official or employee is no longer requested.

(d) The Department of Health and Social Services shall notify an official identified under (a) of this section of the opportunity for a parent to file a grievance under AS 47.10.098 when the official is denied access to all or part of a requested record

(e) A person who violates a provision of this section is guilty of a misdemeanor, and upon conviction is punishable by a fine of not more than $500 or by imprisonment for not more than one year, or by both.

HISTORY: (§ 2 ch 98 SLA 1994; am § 50 ch 30 SLA 1996; am § 1 ch 64 SLA 1997; am § 35 ch 99 SLA 1998; am §§ 20, 21 ch 64 SLA 2005)

NOTES:

1 of 1 DOCUMENT

*** CURRENT THRU ALL 2005 LEGISLATION ***
*** ANNOTATIONS CURRENT THRU OPINIONS DECIDED ***
*** AS OF SEPTEMBER 23, 2005 ***

TITLE 47. WELFARE, SOCIAL SERVICES AND INSTITUTIONS
CHAPTER 10. CHILDREN IN NEED OF AID
ARTICLE 1. CHILDREN'S PROCEEDINGS

GO TO CODE ARCHIVE DIRECTORY FOR THIS JURISDICTION

Alaska Stat. § 47.10.093 (2006)

Sec. 47.10.093. Disclosure of agency records

(a) Except as permitted in AS 47.10.092 and in (b) — (g) and (i) — (*l*) of this section, all information and social records pertaining to a child who is subject to this chapter or AS 47.17 prepared by or in the possession of a federal, state, or municipal agency or employee in the discharge of the agency's or employee's official duty are privileged and may not be disclosed directly or indirectly to anyone without a court order.

(b) A state or municipal agency or employee shall disclose appropriate confidential information regarding a case to

(1) a guardian ad litem appointed by the court;

(2) a person or an agency requested by the department or the child's legal custodian to provide consultation or services for a child who is subject to the jurisdiction of the court under AS 47.10.010 as necessary to enable the provision of the consultation or services;

(3) an out-of-home care provider as necessary to enable the out-of-home care provider to provide appropriate care to the child, to protect the safety of the child, and to protect the safety and property of family members and visitors of the out-of-home care provider;

(4) a school official as necessary to enable the school to provide appropriate counseling and support services to a child who is the subject of the case, to protect the safety of the child, and to protect the safety of school students and staff;

(5) a governmental agency as necessary to obtain that agency's assistance for the department in its investigation or to obtain physical custody of a child;

(6) a law enforcement agency of this state or another jurisdiction as necessary for the protection of any child or for actions by that agency to protect the public safety;

(7) a member of a multidisciplinary child protection team created under AS 47.14.300 as necessary for the performance of the member's duties;

(8) the state medical examiner under AS 12.65 as necessary for the performance of the duties of the state medical examiner;

(9) a person who has made a report of harm as required by AS 47.17.020 to inform the person that the investigation was completed and of action taken to protect the child who was the subject of the report;

(10) the child support services agency established in AS 25.27.010 as necessary to establish and collect child support for a child who is a child in need of aid under this chapter;

(11) a parent, guardian, or caregiver of a child or an entity responsible for ensuring the safety of children as necessary to protect the safety of a child; and

(12) a review panel established by the department for the purpose of reviewing the actions taken by the department in a specific case.

(c) A state or municipal law enforcement agency shall disclose information regarding a case that is needed by the person or agency charged with making a preliminary investigation for the information of the court under AS 47.10.020.

(d) *[Repealed, § 55 ch 59 SLA 1996.]*

(e) *[Repealed, § 55 ch 59 SLA 1996.]*

(f) The department may release to a person with a legitimate interest confidential information relating to children not subject to the jurisdiction of the court under AS 47.10.010.

(g) The department and affected law enforcement agencies shall work with school districts and private schools to develop procedures for the disclosure of confidential information to a school official under (b)(4) of this section. The procedures must provide a method for informing the principal or the principal's designee of the school that the student attends as soon as it is reasonably practicable.

(h) *[Repealed, § 55 ch 59 SLA 1996.]*

(i) The commissioner of health and social services or the commissioner's designee or the commissioner of administration or the commissioner's designee, as appropriate, may disclose to the public, upon request, confidential information, as set out in (j) of this section, when

(1) the parent or guardian of a child who is the subject of a report of harm under AS 47.17 has made a public disclosure concerning the department's involvement with the family;

(2) the alleged perpetrator named in a report of harm under AS 47.17 has been charged with a crime concerning the alleged abuse or neglect; or

(3) a report of harm under AS 47.17 has resulted in the fatality or near fatality of that child.

(j) The type of information that may be publicly disclosed under (i) of this section is information related to the determination, if any, made by the department regarding the validity of a report of harm under AS 47.17 and the department's activities arising from the department's investigation of the report. The commissioner or the commissioner's designee

(1) shall withhold disclosure of the child's name, picture, or other information that would readily lead to the identification of the child if the department determines that the disclosure would be contrary to the best interests of the child, the child's siblings, or other children in the child's household; or

(2) after consultation with a prosecuting attorney, shall withhold disclosure of information that would reasonably be expected to interfere with a criminal investigation or proceeding or a criminal defendant's right to a fair trial in a criminal proceeding.

(k) Except for a disclosure made under (i) of this section, a person to whom disclosure is made under this section may not disclose confidential information about the child or the child's family to a person not authorized to receive it.

(*l*) The Department of Health and Social Services and the Department of Administration shall adopt regulations to implement and interpret the duties of the respective department under this section, including regulations governing the release of confidential information and identifying a sufficient legitimate interest under (f) of this section.

(m) A person may not bring an action for damages against the state, the commissioner, or the commissioner's designee based on the disclosure or nondisclosure of information under (i) of this section except for civil damages resulting from gross negligence or reckless or intentional misconduct.

(n) A person who discloses confidential information in violation of this section is guilty of a class B misdemeanor.

(o) In this section, "school" means a public or private elementary or secondary school.

HISTORY: (§ 13 ch 113 SLA 1994; am §§ 1, 2 ch 32 SLA 1995; am §§ 32 — 34, 55 ch 59 SLA 1996; am § 4 ch 94 SLA 1997; am § 36 ch 99 SLA 1998; am § 69 ch 35 SLA 2003; am § 31 ch 99 SLA 2004; am §§ 22 — 27 ch 64 SLA 2005)

NOTES:

REVISOR'S NOTES.—A reference to "AS 47.10.092" was inserted in (a) of this section in 1994 to harmonize the amendments to AS 47.10 made by ch. 98, SLA 1994, and ch. 113, SLA 1994.

Subsections (g) and former (h) were enacted as (h) and (i), respectively. Relettered in 1995, at which time former subsection (g) was relettered as (i) and the internal reference in (a) was conformed.

In 2004, "child support enforcement agency" was changed to "child support services agency" in (b) of this section in accordance with § 12(a), ch. 107, SLA 2004.

Subsections (i) — (m) were enacted as (k) — (o) and relettered in 2005, at which time former subsections (i) and (j) were relettered as subsections (n) and (o) and internal references in subsections (a), (i), (j), (k), and (m) were conformed.

CROSS REFERENCES.—For similar provisions relating to delinquent minors, see AS 47.12.310.

EFFECT OF AMENDMENTS.—The 1995 amendment, effective May 20, 1995, added a subsection reference in subsection (a) and added subsections (g), former (h), and (j).

The 1996 amendment, effective September 10, 1996, in subsection (a), deleted ", including driver's license actions under AS 28.15.185," following "official duty" near the end and made a section reference substitution; in subsection (b), repealed paragraph (6), made a subsection reference substitution, and made minor related changes; in subsection (c), repealed paragraphs (2)–(5); in subsection (g), deleted a section reference; and repealed subsections (d), (e), and (h).

The 1997 amendment, effective June 21, 1997, in subsection (b), inserted "board or local review" near the middle of paragraph (1) and, in paragraph (3), inserted "enable the school to provide appropriate counseling and support services to the minor who is the subject of the case, to protect the safety of the minor who is the subject of the case, and to."

The 1998 amendment, effective September 14, 1998, rewrote subsection (b).

The 2003 amendment, effective June 3, 2003, deleted "or to a citizen review board or local review panel for permanency planning authorized by AS 47.14.200 or 47.14.220" from the end of paragraph (b)(1).

The 2004 amendment, effective June 26, 2004, substituted "(b)(4)" for "(b)(3)" in the first sentence of subsection (g).

The 2005 amendment, effective July 1, 2005, in subsection (a) substituted "permitted" for "specified," updated subsection references, and substituted "child" for "minor"; in subsection (b) added paragraphs (11) and (12) and otherwise rewrote the subsection; rewrote subsection (c); in subsection (f) inserted "confidential", substituted "children" for "minors", and deleted the last sentence; in subsection (g) inserted "confidential" and made stylistic changes; and added subsections (k)-(o) [now (i)-(m)].

EDITOR'S NOTES.—Section 16(2), ch. 113, SLA 1994 provides that this section, as added by § 13, ch. 113, SLA 1994 "applies to offenses committed on or after September 1, 1994."

Section 61(b), ch. 64, SLA 2005, provides that the 2005 amendments of this section have "the effect of changing Rule 22, Alaska Child in Need of Aid Rules of Procedure, by allowing the disclosure of confidential information pertaining to a child, including a child's name or picture to be made public in certain circumstances."

Under § 62(b), ch. 64, SLA 2005, the 2005 amendments to this section apply "to all proceedings and hearings conducted on or after July 1, 2005."

Under § 62(c), ch. 64, SLA 2005, the 2005 amendments to this section "apply to all information, records, and files created on or after July 1, 2005; however, if a file contains information and records that were created before July 1, 2005, that information and those records retain the confidentiality that they had under the law on June 30, 2005."

USER NOTE: For more generally applicable notes, see notes under the first section of this article, chapter or title.

Alaska Conference of Catholic Bishops

415 Sixth Street, Suite 300
Juneau, Alaska 99801
Ph (907) 586-2404 / Fax (907) 586-2405
E-mail citw@alaska.net

March 3, 2006

The Honorable Johnny Ellis
State Senate
Alaska State Capitol
Juneau, Alaska 99801-1182

Dear Senator Ellis:

On behalf of the Alaska Conference of Catholic Bishops, I would like to thank-you for sponsoring Senate Bill 287, an act establishing a higher education savings program for children in state foster care. The Alaska Conference of Catholic Bishops is the official public policy voice of the Roman Catholic Church in Alaska.

We appreciate your thoughtfulness in proposing an innovative way to assist eligible children in foster care to pursue educational opportunities beyond grade 12. Foster care children, like many other vulnerable persons, are often out of sight and out of mind of those of us who have the financial resources for a dignified life. We also commend you for proposing a mechanism by which Alaskans who have the financial ability can help to contribute to the higher education costs of those who do not have the financial ability. Turning from self-love toward love of neighbor is a central teaching of the Gospel message. S B 287 provides another way for Alaskans to put this teaching into practice and we support it.

Sincerely,

Chip Wagoner
Executive Director
Alaska Conference of Catholic Bishops

ALASKA COMMUNITY SERVICES, INC.

Helping Alaska's Seniors — Help Alaska

ANCHORAGE

1057 W. Fireweed Lane, #103
Anchorage, AK 99503

Phone: (907) 276-6472
Fax: (907) 276-6475

www.akcommunityservices.org

FAIRBANKS

HOMER

JUNEAU

KENAI

KETCHIKAN

SEWARD

WASILLA

April 13, 2006

Senator Johnny Ellis
Minority Leader
Alaska State Legislature
State Capitol, Rm 9
Juneau, AK, 99801

Dear Senator Ellis,

Thank you for your letter concerning Senate Bill 287. I am very pleased that you are proposing legislation that offers increased opportunities for Foster Children in the state of Alaska. I too believe that these children deserve and should be able to take every advantage of programs that enhance their ability to succeed in life and become responsible, productive adults.

Alaska Community Services volunteers provide services to these and many other children across the state through our Foster Grandparent Program. I am certain that they are also concerned with the future of these children, and will lend their support to this legislation. I will request the support of my legislators for SB 287 and also ask that my colleagues do so as well.

During this time when most of our focus seems to be primarily on pipelines and taxes, I thank you for your ongoing support of and commitment to programs that address the needs of disadvantaged or devalued Alaskans.

Sincerely,

Mike Saville
Executive Director

STATEMENT OF SUPPORT

Establishing Education Savings Accounts for Foster Children in Alaska

Children in the foster care system face significant challenges when they age out of state care. Often, these children do not have a plan or the means to access job training or post-secondary education. With a program in place whereby concerned organizations and citizens can establish savings accounts in the names of foster children, these children will have opportunities beyond high school.

Alaska's foster children deserve a program that invests in their potential. Alaska should create a program designed to give children in foster care the opportunity to pursue education and job training past the age of 18.

Please add my name/organization to the list of supporters.

Name Jim Maley
Organization ALASKA CHILDREN'S SERVICES
Title PRESIDENT / CEO
Signature
Address 4600 ABBOTT RD / ANCHORAGE 99507
Phone (907) 346-2101 Fax 348-9230
Email AKCHILD@AK.NET Website WWW.ACS.AK.ORG

I/We would also be willing to:

- ✓ Publish an article in our newsletter
- ✓ Participate in media events
- ✓ Contact legislators
- ✓ Mobilize our membership
- Help to build a coalition

Please return this form to:
Office of Senator Johnny Ellis
State Capitol, Rm. 9
Juneau, AK 99801

Great plan, Johnny

STATEMENT OF SUPPORT
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Please add my name/organization to the list of supporters.

Name Walter Majoros
Organization Juneau Youth Services
Title Executive Director
Signature Walter Majoros
Address PO Box 32839, Juneau AK 99803
Phone 907-796-4131 Fax 907-789-2106
Email waltermo@jys.org Website www.jys.org

I/We would also be willing to:

__Publish an article in our newsletter
__Participate in media events
✓Contact legislators
__Mobilize our membership
✓Help to build a coalition

Please return this form to:
Office of Senator Johnny Ellis
State Capitol, Rm. 9
Juneau, AK 99801

Sounds like a good bill.
Thanks, Johnny!
Walter

STATEMENT OF SUPPORT

Establishing Education Savings Accounts for Foster Children in Alaska

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Please add my name/organization to the list of supporters.

Name Mertis Johnson
Organization EASY Living Adult Care
Title Owner
Signature Mertis Johnson
Addre Mertis Johnson' Ave
Phc 7710 Mary Land Ave Fax 333-3562
Em 333-1846 Website

I/We would also be willing to:

__Publish an article in our newsletter
__Participate in media events
__Contact legislators
__Mobilize our membership
__Help to build a coalition

Please return this form to:
Office of Senator Johnny Ellis
State Capitol, Rm. 9
Juneau, AK 99801

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Establishing Education Savings Accounts for Foster Children in Alaska

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Alaska's foster children deserve a program that invests in their potential. Alaska should create a program designed to give children in foster care the opportunity to pursue education and job training past the age of 18.

Please add my name/organization to the list of supporters.

Name Eileen M. Lally
Organization
Title
Signature Eileen M. Lally
Address 6508 Fairbanks Dr Anchorage 99518
Phone 907 786 6731 Fax
Email Website

I/We would also be willing to:

__Publish an article in our newsletter
__Participate in media events
__Contact legislators
__Mobilize our membership
__Help to build a coalition

Please return this form to:
Office of Senator Johnny Ellis
State Capitol, Rm. 9
Juneau, AK 99801

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Please add my name/organization to the list of supporters.

Name Kathryn Carsson
Organization Gateway Center for Human Services
Title Director
Signature [signature]
Address 3050 Fifth Ave Ketchikan 99901
Phone 907 228 6521 Fax 907 247 4135
Email Kathyc@City.Ketchikan.AK.US Website

I/We would also be willing to:

__Publish an article in our newsletter
X Participate in media events
X Contact legislators
X Mobilize our membership
__Help to build a coalition

Please return this form to:
Office of Senator Johnny Ellis
State Capitol, Rm. 9
Juneau, AK 99801

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 28, 2006

SUBJECT: SB 287 (Work Order No. 24-LS1621\G)

TO: Senator Johnny Ellis
Attn: Gabriel Aceves

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Establishes a program within the Department of Health and Social Services to encourage investment in savings for the higher education of eligible foster children.

Section 2. Provides for the disclosure of appropriate confidential information pertaining to a case involving a child in need of aid, including a foster child, to the Board of Regents of the University of Alaska to the extent necessary to support the program established under section one.

Section 3. Provides for the disclosure of appropriate confidential information pertaining to a case involving a child who is adjudicated as delinquent, to the Board of Regents of the University of Alaska to the extent necessary to support the program established under section one.

JMM:med
06-174.med

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB287-DHSS-OCS-03-01-06
( ) Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Health & Social Services

Title: ESTABLISHING A HIGHER EDUCATION FUND FOR PERSONS PLACED IN FOSTER CARE
RDU: Children's Services
Component: Children's Services Management

Sponsor: ELLIS
Requester: SENATE (HES)
Component No.: 2666

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

SB 287 provides the ability for churches, community organization, non-profits, businesses and individuals to establish education savings accounts in the name of foster children. The Office of Children's Services estimates no significant fiscal impact if this bill were to become law.

Prepared by: Tammy Sandoval, Deputy Commissioner — Phone 465-3191
Division: Office of Children's Services — Date/Time 03/01/2006
Approved by: Karleen Jackson, Commissioner — Date 03/01/2006
Agency: Department of Health and Social Services

(Revised 9/7/2005 OMB)

BOYS & GIRLS CLUBS
www.bgcalaska.org

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Fax: 907-248-0047

President & CEO
John P. Oates
Tel: 907-770-7337
Fax: 907-770-7348
joates@bgcalaska.org

Senator Johnny Ellis
State Capitol Room 9
Juneau, Alaska 99801

April 19, 2006

Dear Senator Ellis,

On behalf of Boys & Girls Clubs Board of Directors and professional staff, we are writing to extend Boys & Girls Clubs' support for Senate Bill 287, legislation designed to help provide higher education opportunities for foster children. As you are well aware, our organization has been operating youth development programs for 40 years. In 1998, we eagerly undertook a Statewide Expansion Initiative that has developed Clubhouses in 29 rural Alaskan communities. This initiative, combined with our steady expansion in urban communities, has broadened our total impact to 30,000 youth in 38 Alaskan communities.

Our members' challenges range from peer pressure to poor grades, hunger, abusive homes, or multiple foster home placements. For every child that walks through a Clubhouse door, we listen, we comfort, we challenge and cheer. Many of our staff, volunteers and program partners establish personal connections and mentor relationships with our members in foster care. SB 287 will provide them with an avenue to have a lasting impact on these children well into adulthood.

Again, thank you for sponsoring this legislation. Boys & Girls Club appreciates your support of our programs and your commitment to Alaska's youth.

Sincerely,

Alan Budahl
Board of Directors, Chair

John P. Oates
President and Chief Executive

Investing in Alaska's most valuable resource – our children.

24-LS1621\F
Mischel
4/18/06

CS FOR SENATE BILL NO. 287( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATOR ELLIS

A BILL

FOR AN ACT ENTITLED

"An Act establishing a higher education savings program for eligible persons who were placed in foster care by the state; and providing for confidentiality of identifying information of a beneficiary under the program."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 47.05 is amended by adding a new section to read:

Article 4. Alaska Higher Education Savings Program for Foster Children.

Sec. 47.05.400. Higher education savings program. (a) The department shall administer a program to encourage investment by a person or entity in the higher education of eligible foster children in the state. The program must include

(1) a central office, dedicated to faith-based and community services, for development and marketing of the program;

(2) a mechanism for the University of Alaska to establish and maintain a University of Alaska college savings plan under AS 14.40.802 - 14.40.817 for an eligible child who is a beneficiary of the program;

(3) a process for identifying donors and eligible beneficiaries;

(4) a process for distributing nonconfidential information about an eligible beneficiary to a potential donor, including the age, sex, and general location of the beneficiary;

(5) terms and conditions for participation in the program that are consistent with the University of Alaska college savings plan restrictions and with federal law pertaining to higher education savings accounts; and

(6) a procedure for monitoring success of the program, for record keeping, and for maintaining confidentiality of records as required by federal and state law.

(b) A person is eligible for participation in the higher education savings program for foster children as a beneficiary if the person was ordered committed to the custody of the department under AS 47.10.080(c) or AS 47.12.120(b)(3), was placed in a foster home for not less than two years, and is a resident of the state.

(c) The commissioner or the commissioner's designee may name a new beneficiary to an existing college savings plan established under (a) of this section if the new designation is not prohibited under federal law or under the University of Alaska college savings plan and if the named beneficiary dies, fails to enroll in an eligible program before the beneficiary becomes 30 years of age, or fails to meet conditions established in regulations adopted by the commissioner.

(d) Identifying information of a beneficiary contained in records related to the program is confidential.

(e) In this section,

(1) "beneficiary" has the meaning given in AS 14.40.802;

(2) "donor" means the person or entity who contributes to the higher education savings program for foster children for the purpose of establishing or contributing to a college savings account established for a foster child under this section;

(3) "college savings plan" means a post secondary education savings program or advanced college savings tuition savings contract established under AS 14.40.802 - 14.40.817.

* **Sec. 2.** AS 47.10.093(b) is amended to read:

(b) A state or municipal agency or employee shall disclose appropriate confidential information regarding a case to

(1) a guardian ad litem appointed by the court;

(2) a person or an agency requested by the department or the child's legal custodian to provide consultation or services for a child who is subject to the jurisdiction of the court under AS 47.10.010 as necessary to enable the provision of the consultation or services;

(3) an out-of-home care provider as necessary to enable the out-of-home care provider to provide appropriate care to the child, to protect the safety of the child, and to protect the safety and property of family members and visitors of the out-of-home care provider;

(4) a school official as necessary to enable the school to provide appropriate counseling and support services to a child who is the subject of the case, to protect the safety of the child, and to protect the safety of school students and staff;

(5) a governmental agency as necessary to obtain that agency's assistance for the department in its investigation or to obtain physical custody of a child;

(6) a law enforcement agency of this state or another jurisdiction as necessary for the protection of any child or for actions by that agency to protect the public safety;

(7) a member of a multidisciplinary child protection team created under AS 47.14.300 as necessary for the performance of the member's duties;

(8) the state medical examiner under AS 12.65 as necessary for the performance of the duties of the state medical examiner;

(9) a person who has made a report of harm as required by AS 47.17.020 to inform the person that the investigation was completed and of action taken to protect the child who was the subject of the report;

(10) the child support services agency established in AS 25.27.010 as necessary to establish and collect child support for a child who is a child in need of aid under this chapter;

(11) a parent, guardian, or caregiver of a child or an entity responsible for ensuring the safety of children as necessary to protect the safety of a child; [AND]

(12) a review panel established by the department for the purpose of reviewing the actions taken by the department in a specific case**; and**

(13) the University of Alaska under the Alaska higher education savings program for foster children established under AS 47.05.400, but only to the extent that the information is necessary to support the program and only if the information released is maintained as a confidential record by the University of Alaska.

*** Sec. 3.** AS 47.12.310(b) is amended to read:

(b) A state or municipal agency or employee shall disclose

(1) information regarding a case to a federal, state, or municipal law enforcement agency for a specific investigation being conducted by that agency; [AND]

(2) appropriate information regarding a case to

(A) a guardian ad litem appointed by the court;

(B) a person or an agency requested by the department or the minor's legal custodian to provide consultation or services for a minor who is subject to the jurisdiction of the court under this chapter as necessary to enable the provision of the consultation or services;

(C) school officials as may be necessary to protect the safety of the minor who is the subject of the case and the safety of school students and staff or to enable the school to provide appropriate counseling and supportive services to meet the needs of a minor about whom information is disclosed;

(D) a governmental agency as may be necessary to obtain that agency's assistance for the department in its investigation or to obtain physical custody of a minor;

(E) a law enforcement agency of this state or another jurisdiction as may be necessary for the protection, rehabilitation, or supervision of any minor or for actions by that agency to protect the public safety;

(F) a victim or to the victim's insurance company as may be necessary to inform the victim or the insurance company about the arrest of the minor, including the minor's name and the names of the minor's parents, copies of reports, or the disposition or resolution of a case involving a minor;

(G) the state medical examiner under AS 12.65 as may be necessary to perform the duties of the state medical examiner;

(H) foster parents or relatives with whom the child is placed by the department as may be necessary to enable the foster parents or relatives to provide appropriate care for the child who is the subject of the case, to protect the safety of the child who is the subject of the case, and to protect the safety and property of family members and visitors of the foster parents or relatives;

(I) the Department of Law or its agent for use and subsequent release if necessary for collection of an order of restitution on behalf of the recipient;

(J) the Violent Crimes Compensation Board established in AS 18.67.020 for use in awarding compensation under AS 18.67.080; and

(K) a state, municipal, or federal agency of this state or another jurisdiction that has the authority to license adult or children's facilities and services**; and**

(3) to the University of Alaska under the Alaska higher education savings program for foster children established under AS 47.05.400, information that is necessary to support the program, but only if the information released is maintained as a confidential record by the University of Alaska.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB287-DHSS-OCS-03-01-06
( ) Publish Date:

Revision Date/Time (Note if correction)

Dept. Affected: Health & Social Services

Title: ESTABLISHING A HIGHER EDUCATION FUND FOR PERSONS PLACED IN FOSTER CARE

RDU: Children's Services

Component: Children's Services Management

Sponsor: ELLIS

Requester: SENATE (HES)

Component No: 2666

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (0)						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1037 GF/Mental Health						
Other(Specify Type-do not abbreviate)						
Other(Specify Type-do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost:
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

SB 287 provides the ability for churches, community organization, non-profits, businesses and individuals to establish education savings accounts in the name of foster children. The Office of Children's Services estimates no significant fiscal impact if this bill were to become law.

Prepared by: Tammy Sandoval, Deputy Commissioner — Phone: 465-3191
Division: Office of Children's Services — Date/Time: 03/01/2006
Approved by: Karleen Jackson, Commissioner — Date: 03/01/2006
Agency: Department of Health and Social Services

(Revised 9/7/2005 OMB)

SENATOR FRED DYSON

MEMORANDUM

To: Senate H.E.S.S. Committee Members

From: Senator Fred Dyson

Date: April 29, 2006

Re: Foster youth educational opportunities

In the committee's discussion of SB 287, I requested that the Office of Children's Services provide us with information on educational grant programs for foster youth in Alaska. Attached is information on the Education & Training Vouchers and the University of Alaska Tuition waiver.

During Session (January-May): Alaska State Capitol • Juneau, Alaska 99801 • (800) 342-2199 • (907) 465-2199 • (907) 465-4587 FAX
During Interim (June-December): 10928 Eagle River Road • Eagle River, Alaska 99577 • (907) 694-6683 • (907) 694-1015 FAX
Senator.Fred.Dyson@Legis.state.ak.us • www.akrepublicans.org

Education and Training Vouchers (ETV)

The Education and Training Voucher (ETV) program was authorized under the Chafee Foster Care Independence Act, signed into law in January 2002. Funds for this program were awarded to the State in August 2003. The funds are going to assist foster youth and eligible former foster youth in attending post secondary education and training programs.

The education or training program must meet the following criteria:

- Awards a bachelor's degree or not less than a 2 year program that provides credit towards a degree or
- Provides not less than 1 year of training towards gainful employment or
- Is a vocational program that provides training for gainful employment and has been in existence for t least two years

And must meet all three of the following criteria:

- Admits as regular students only persons with a high school diploma or equivalent, or admits as regular students persons who are beyond the age of compulsory school attendance
- Public or Non-Profit
- Accredited or preaccredited and is authorized to operate in that state

More information about the ETV funding and federal regulations can be found at

http://www.nrcys.ou.edu/NRCYD/etv.htm

University of Alaska Tuition Waiver

The University of Alaska in partnership with the Office of Children's Services provide five full tuition waivers per year to eligible foster youth and former foster youth. When combined with Federal student aid and an Education or Training Voucher, the successful applicant will receive a cost free university education!

Hey! If you are planning to go to college in the fall, the deadline for turning in a Scholarship Application for this year is June 1, 2004!

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University of Alaska Foster Youth Tuition Waiver

This application is used to apply for a tuition waiver and additional assistance for individuals who were in foster care in the state of Alaska on their 18th birthday. The tuition waiver is open to students who have been accepted to any campus of the University of Alaska (Anchorage, Fairbanks, Southeast and all community campuses). Additional assistance for housing, the meal plan, and University fees may also be requested through this application.

Review the Foster Youth Tuition Waiver information on the second page of this application for a complete description of the program, the type of assistance provided, and eligibility requirements.

If you have any questions about this application, or need some assistance, please call:

Jennifer Jennings	or	Deirdre O'Connor
(800) 797-7495		(907) 465-3209

APPLICATION INSTRUCTIONS

1. Fill out the entire application. Keep in mind the requirement to explore other scholarships first before applying for the Foster Youth Tuition Waiver.

2. Attach your most recent transcripts. Please remember to request your transcripts from your High School or college in time to be turned in with your application. ***They are required for a complete application.*** Unofficial transcripts are acceptable and preferred.

3. Attach letters of recommendation from two (2) references. Inform your references that their letters must be to you in time to be turned in with your application—do not send them separate from your application! Letters can be from Teachers, counselors, clergy, and coaches. Preferred references are from your DFYS Social Worker and a Foster Parent or caregiver. ***References are required and must be current within the past two years.***

4. Attach a personal essay. Your personal essay should describe your educational goals and objectives, your involvement in curricular and extracurricular activities, your employment history, and your plans for utilizing your education after you receive your degree. It should be no longer than one (1) page. ***This essay is a required part of your application.***

DO NOT attach tax information, photos, or other personal information not required for application. Mail the application, the essay, two reference letters, and transcripts in the same envelope by May 1, 2003 to:

Attention: Deirdre O'Conner
Independent Living Program Coordinator
Division of Family and Youth Services
P.O. Box 110630
Juneau, AK 99811

Failure to adhere to these requirements and/or submitting an incomplete application may result in disqualification.

University of Alaska Foster College Scholarship

BACKGROUND

The University of Alaska College Scholarship provides young people who have left foster care because they have attained 18 years of age or older (often termed aging out) in Alaska a chance to have a university education. The Scholarship consists of two parts: a tuition waiver from the University of Alaska, and Additional Assistance from the Division of Family and Youth Services. Eligibility for Tuition Waiver and the Additional Assistance are slightly different.

There are five tuition waivers offered per year. These waivers are available to students whom the Division of Family and Youth Services awards based upon eligibility criteria, need, and scholarship. Each waiver is effective for four years, (eight semesters) of full-time attendance at any campus of the University of Alaska. Waivers will not be used for less than full-time attendance. University criteria will apply (i.e.: good academic standing, financial requirements met, and student code of conduct standing) to continue the waiver.

Through the Division of Family and Youth Services Independent Living program, most students who enter the University through this tuition waiver program will be offered the opportunity to receive housing assistance, assistance for required books and materials, a full meal plan, and payment of University fees during the period that they receive the tuition waiver. If receiving housing assistance, the first two years (four semesters) of housing assistance must be in University housing or with former foster care providers. Additional Assistance is offered only to students receiving the Tuition Waiver and only to students who are under 21 years of age. For more information, see **ADDITIONAL ASSISTANCE** below.

The scoring of applications will be made by a five-member awards committee consisting of the Division of Family and Youth Services Independent Living Program Coordinator, a University of Alaska Admissions Coordinator, a youth member of the Independent Living Youth Advisory Board, a representative from the Governor's Office of Equal Employment Opportunity, and a member of the public at-large.

ELIGIBILITY

In order to be eligible for the University of Alaska Foster Youth Tuition Waiver program, you must:

- Be a resident of Alaska,
- Have been or will be in foster care on your 18th birthday,
- Be accepted for full-time enrollment into the University of Alaska,
- Have a demonstrated financial need for financial assistance,
- Have applied for at least two other scholarships.

If you are awarded a tuition waiver, you do not need to reapply for it so long as you:

- Are a full-time student,
- Maintain a minimum 2.0 Grade Point Average
- Maintain good academic standing, student code of conduct standing, and meet University financial requirements.

ADDITIONAL ASSISTANCE

The University of Alaska Foster Youth Tuition Waiver does not include payment of University Fees, student housing, costs for books and other materials, or the meal plan. The Division of Family and Youth Services offers limited assistance for fees, housing, and the meal plan for students who are awarded a Foster Youth Tuition Waiver. You may request Additional Assistance for housing, the meal plan, and University fees on your College Scholarship application.

To be eligible for Housing, Fees, Books, Room and Board assistance, you must:

- be 18 years or older but not attained 21 years of age,
- be receiving the University of Alaska Tuition waiver in good standing,
- complete your first two years at the University in University Housing (if available) or with your former foster care providers.

Just like the Tuition Waiver, you do not need to reapply for this assistance so long as you remain a full-time student in good standing and are within the age limits for additional assistance. You must, however, live in University housing (if available) or with your former foster care providers for the first two-years of school attendance. After two years, you can choose to remain in University housing or receive housing assistance up to the amount that a dormitory-style room would cost at your campus.

While you must be receiving the Tuition Waiver to receive Housing, Fee, Room and Board assistance, you are not required to receive the additional assistance to be awarded the waiver. Additionally, you may request or be awarded partial assistance depending upon your need.

OTHER FINANCIAL AID

Because there are only a limited number of University of Alaska College Scholarships to award each year, applicants are encouraged to research other scholarship opportunities in addition to this program. The application format for this program is very similar to the University of Alaska Foundation Scholarships application, so applying for additional opportunities is easy. Two applications for other scholarships are required in order to be eligible for the Foster Youth Tuition Waiver.

SB

299

ALASKA STATE SENATE

Session:
State Capitol
Juneau, Alaska 99801-1182
(907) 465-2327
(907) 465-5241 Fax

Interim:
119 N. Cushman, Suite 201
Fairbanks, Alaska 99701
(907) 456-8161
Senator_Ralph_Seekins@legis.state.ak.us

Senator Ralph Seekins
District D

MEMORANDUM

Date: February 14, 2006

To: Office of Senator Dyson

From: Senator Ralph Seekins

Re: Request for Scheduling of SB 299

Attached please find Senate Bill 299 along with a concomitant sponsor statement.

Senate Bill 299 incorporates into Alaska law "any willing provider" language allowing individuals to make their own choices regarding health care providers so long as the service provider is willing to abide by the network terms, conditions and pay scale.

I respectfully request this bill be scheduled for a hearing in the Health, Education & Social Services Committee at your earliest convenience.

Thank you.

ALASKA STATE SENATE

Session:
State Capitol
Juneau, Alaska 99801-1182
(907) 465-2327
(907) 465-5241 Fax

Interim:
119 N. Cushman, Suite 201
Fairbanks, Alaska 99701
(907) 456-8161
Senator_Ralph_Seekins@legis.state.ak.us

Senator Ralph Seekins
District D

Senate Bill 299 Sponsor Statement

"An Act relating to preventing unfair discrimination against a health care provider who is willing to meet a health insurer's terms and conditions for participation in the insurer's plan, policy, or contract for health care services; amending the definition of 'provider' as it relates to authorized collective negotiations by physicians affecting the rights of providers under health benefit plans."

Alaska Statute 21.36.090(d) pertains to unfair discrimination against a person who provides services covered under a group health insurance plan. This law comes into play as a function of the relationship between health care providers and group health care systems. Recently the U.S. Supreme Court upheld Kentucky's "any willing provider" (AWP) law. The language used in this law essentially offers a more robust alternative to Alaska's current law.

Senate Bill 299 repeals AS 21.36.090(d) and replaces it with case tested AWP language. The move towards AWP verbiage also required a change to the definition of "health care provider". In so doing, the original definition as it's used in Title 23 –Labor and Workers' Compensation – had to be restored. This can be found in Section 2 of the Bill.

Essentially, the AWP concept promotes the individual's ability to choose his or her own health care provider rather than have this decision be directed via a process far removed from the point of contact. The AWP law says that a health insurer cannot discriminate against any provider who is willing to meet the terms and conditions for participation established by the health insurer assuming the provider is located within the geographic coverage area of the health benefit plan.

The AWP issue is especially pertinent in cases where, for example, a woman, in her second trimester of pregnancy, changes jobs. In this instance she may also be forced to change health care providers if her current provider is not recognized by her new health insurance plan. This same scenario also applies in cases where a person takes a job but the pool of physicians offered by the employer's health care plan does not include the individual's long-time family doctor.

In both cases, if the patient's non-network physician is willing to accept the network fee schedule – and meets the insurance company's licensing and credentialing standards – the patient should be able to continue to see their known and trusted doctor rather than be forced to establish a relationship with a new and unknown physician.

Senate Bill 299 adopts into Alaska law the "any willing provider" concept thereby promoting and preserving Alaskan's ability to make their own choices with respect to health care providers.

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 299
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Commerce
Title: Nondiscrimination Health Care Providers
RDU: Insurance (116)
Component: Insurance Operations
Sponsor: Seekins
Requester: Senate HES
Component No.: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2006) cost: 0 0
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This legislation addresses unfair discrimination against a health care provider who is willing to meet a health insurer's terms and conditions for participation in the insurer's plan, policy or contract for health care services It also amends the definition of provider as it relates to authorized collective negotiations by physicians affecting the rights of providers under health benefit plans. It does not impact the operations of the division.

Prepared by: Linda S. Hall, Director — Phone 907-269-7900
Division: Insurance — Date/Time 2/21/06 5:21 PM
Approved by: William C. Noll, Commissioner — Date 2/21/2006
Agency: Commerce, Community, and Economic Development

(Revised 9/7/2005 OMB)

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB299-LAW-C&FB-2-22-
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: LAW
Title "An Act relating to preventing unfair discrimination against a health care provider who is willing to meet a health..."
RDU CIVIL
Component Commercial & Fair Business
Sponsor Senator Seekins
Requester Senate Health, Education and Social Services
Component No.

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2006) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This bill repeals AS 21.36.090(d) relating to prohibiting discrimination against health care providers by health insurers, and reenacts it to emphasize that discrimination against a provider is prohibited when the provider is located in the geographic coverage area of a health plan and will to meet the terms and conditions established by the insurer.

Passage of this legislation will have no fiscal impact on the Department of Law.

Prepared by: Kathryn Daughhetee, Director
Phone 465-3673
Division Administrative Services Division
Date/Time 2/22/06 11:05 AM
Approved by: Kathryn Daughhetee for David Márquez, Attorney General
Date 2/22/2006
Agency Department of Law

(Revised 9/7/2005 OMB)

FISCAL NOTE

STATE OF ALASKA
2006 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 299
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Commerce
Title: Nondiscrimination Health Care Providers
RDU: Insurance (116)
Component: Insurance Operations
Sponsor: Seekins
Requester: Senate HES
Component No.: 354

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below

OPERATING EXPENDITURES	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2006) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2007 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This legislation addresses unfair discrimination against a health care provider who is willing to meet a health insurer's terms and conditions for participation in the insurer's plan, policy or contract for health care services. It also amends the definition of provider as it relates to authorized collective negotiations by physicians affecting the rights of providers under health benefit plans. It does not impact the operations of the division.

Prepared by: Linda S. Hall, Director
Phone 907-269-7900
Division: Insurance
Date/Time 2/21/06 5:21 PM
Approved by: William C. Noll, Commissioner
Date 2/21/2006
Agency: Commerce, Community, and Economic Development

(Revised 9/7/2005 OMB)

PUBLIC EMPLOYEES
LOCAL 71

JIM ASHTON
Business Manager/
Secretary-Treasurer

ROBERT JOHNSON
President

HEADQUARTERS
2510 Arctic Blvd.
Anchorage, Alaska 99503
FAX (907) 279-7171
(907) 276-7211

2122 Airport Way
Fairbanks, Alaska 99701
FAX (907) 456-1771
(907) 452-5024

710 West 9th Street
Juneau, Alaska 99801
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(907) 586-6993

Alaska Senate Bill 299

Any Willing Provider Provisions

SB299 would impact the ability of health plans to obtain favorable negotiated discounts for health care services, because it would open up the health plan's provider network to all providers willing to meet the terms and conditions for participation established by the health insurer.

The increase in health care costs due to AWP statute would likely reduce the number of employers offering health insurance to their employees, or reduce the benefits provided by employers or health plans.

The definition of "health insurer" is sufficiently broad to impact many health plans throughout Alaska, including non-ERISA plans. There is an open question about the extent of ERISA preemption in this area.

Impact: Health plan costs would increase.

- Health plans are currently able to negotiate discounted fees from health providers (hospitals, physicians, pharmacies, and other service providers) because they are able to deliver directed patient volume to contracted providers and reduce administrative burden. This results in a mutually beneficial contractual relationship between providers and health plans.

- Health plans include differential payment provisions to encourage participants to use preferred providers who have agreed to negotiated discounts, thus increasing the preferred provider's volume. In order to obtain the most favorable provider discounts, health plans agree to utilize differential payment provisions.

- Small employers have a low elasticity of demand to price increases in health insurance. As the price of offering health insurance increases, employers will drop (or not offer) coverage to their employees. This resulting burden of additional uninsured consumers in the marker will have a compounding effect on the price of health care in Alaska.

- Other employers would be forced to either increase costs to their employees or reduce the benefits provided.

Opposition to "Any Willing Provider" provisions

1) Health plan costs would increase:

- According to a study by Michael Vita, health care "expenditures are higher when AWP laws are enacted." Michael G.Vita, "Regulatory Restrictions on Selective Contracting: an Empirical Analysis of "Any-Willing-Provider" Regulations, *Journal of Health Economics* 20 (2001) 955-966.
- In an April 8, 2004 letter to the Attorney General of Rhode Island and Deputy Majority Leader of the Senate of Rhode Island, the Federal Trade Commission commented on Any Willing Provider provisions with respect to pharmacy contracting, "Because any pharmacy would be entitled to contract on the same terms as all other pharmacies, there would be little incentive for pharmacies to compete in developing attractive or innovative proposals. Because all other pharmacies can 'free ride' on a successful proposal formulation, innovative providers may be unwilling to bear the costs of developing a proposal. Thus 'any willing provider' requirements may substantially reduce competition among pharmacies...Such strategies may actually reduce the options available to consumers without providing any additional consumer benefit."
- Local provider contracting experience also indicates that any willing provider requirements would increase health plan costs.
    - A recent preferred provider hospital request for proposal (RFP) demonstrated that significantly better discounts were offered when the health plan offered a plan with differential preferred provider (PPO) plan provisions as opposed to a passive PPO arrangement.
    - A recent pharmacy benefits management RFP demonstrated that reducing the pharmacy provider network (selectively contracting) decreased the negotiated rates for pharmacy services
- The National Association of Health Underwriters, in their October 2003 Analysis of State-Level Health Insurance Market Reforms, found that one of the key components to health insurance market stability was the ability of plans to develop appropriate networks and to be able to effectively negotiate discounts with those providers. According to their analysis, "Several states have enacted measures that make it difficult for plans to develop a comprehensive and effective network of providers. For example, a number of states require health plans to accept any willing provider who meets their plan criteria into their networks...Any willing provider mandates may seem like they would benefit consumers, since they allow the greatest number of providers into a plan, but these laws actually have a serious negative consequence. Since any doctor who wishes to participate with a plan can, it makes it much harder for carriers to negotiate any discounts with providers, since there is no financial consequence for non-participation. This leads to higher medical reimbursement costs for all plans in the states, which translates into higher insurance rates for consumers."

- The Federal Trade Commission (FTC) has taken a strong stand in opposition to any willing provider provisions. The Federal Trade Commission and Department of Justice report, *Improving Health Care: A Dose of Competition*, July 2004, states,
    - "Commission staff has expressed concerns about AWP (Any Willing Provider) and FOC (Freedom of Choice) laws, noting that they could have anticompetitive effects and harm consumers. These laws can make it more difficult for health insurers to negotiate discounts from providers in exchange for the higher patient volume that would likely result from restricted provider networks. They can also limit competition, by restricting the ability of insurance companies to structure different plans with varying levels of choice in response to consumer demand. These restrictions on competition may result in insurance companies paying higher fees to providers, which in turn generally results in higher premiums, and may increase the number of uninsured Americans."
    - "Many provider groups support AWP and FOC legislation. Commission staff observed in its most recent advocacy letter that "several scholars have noted that any willing provider and 'freedom of choice' laws are **more likely to appear in states with limited managed care penetration**, and suggested that these provisions are actually intended to preempt competition among providers [provider protection], instead of protecting the interest of patients." [emphasis added]
    - "When insurers have a credible threat to exclude providers from their networks and channel patients elsewhere, providers have a powerful incentive to bid aggressively. Inclusion in a restricted panel offers the provider the prospect of substantially increased revenue. Without such credible threats, however, providers have less incentive to bid aggressively, and even managed care organizations with large market shares may have less ability to obtain low prices."
    - The FTC Staff letter to Rhode Island, which was excerpted in the FTC/DOJ report, stated, "Empirical evaluations of any willing provider and 'freedom of choice' provisions indicate that these policies result in higher health care expenditures. One study found that states with highly restrictive any willing provider /freedom of choice laws spent approximately 2% more on healthcare than did states without such policies."

2) Fewer small employers will offer health insurance due to AWP legislation

- The FTC further predicts the number of employees covered by health insurance will drop in the presence of anticompetitive conduct advanced by AWP legislation. The Federal Trade Commission and Department of Justice report, *Improving Health Care: A Dose of Competition*, July 2004, states,

- "When anticompetitive conduct increases prices, it makes it more difficult for many Americans to obtain needed care. Estimates of the price elasticity of health insurance vary, but many small employers do not offer health insurance at all because it is too expensive. When employers offer health insurance, price increases can result in limitations on coverage, employees refusing to sign up for insurance, and employers dropping coverage."

- According to a study published in the Journal of Human Resources, if monthly premiums to firms increased by $1, the proportion of firms offering health insurance to employees would decrease by almost 2 percentage points. Roger Feldman, et al., "The Effect of Premiums on the Small Firm's Decision to Offer Health Insurance," 32 *Journal of Human Resources* 635 (1997).

We believe that in a market like ours with almost no penetration of managed care, AWP legislation will harm consumers through an increase in the price of health care and a decrease in the availability of employer-sponsored health plans.

AMENDMENT _____

OFFERED IN THE SENATE HESS COMMITTEE

FOR SB 299

Page 1, lines 21-22

delete all material

renumber section accordingly.

Improving Health Care: A Dose of Competition

any mandated benefits.[185] According to several panelists, mandates increase premiums and decrease wages and other benefits employers might otherwise offer.[186]

Other commentators assert that state-imposed mandated benefits disproportionately affect small businesses because they are less able to avoid the costs of such mandates by self-insuring.[187] Although determining the actual cost of an individual mandated benefit can be difficult, the aggregate cost of such mandates appears to account for a substantial percentage of premium cost.[188]

Finally, some commentators have noted the behavioral economic arguments in favor of mandated benefits are theoretical, and not based on empirical evidence regarding the performance of the health insurance market.[189] Mandate proponents presented no evidence that consumers demand insufficient health insurance, and there is some evidence that many consumers actually demand excessive health insurance.[190] Mandate proponents presented no evidence that government intervention is likely to improve the efficiency of health insurance benefit design, and there is some evidence to the contrary.[191]

3. Any Willing Provider and Freedom of Choice Legislation: A Case Study of Mandates

Any willing provider (AWP) laws require managed care companies to include in their networks any provider that is willing to participate in the plan in accordance with the plan's terms.[192] Freedom of choice (FOC) laws are similar to AWP laws, but are directed at consumers instead of providers.[193] Many states have adopted AWP and/or FOC laws for at least some

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[185] Knettel 6/25 at 73-75 (noting that each time a benefit is mandated that mandate "is going to be offset by a benefit reduction of equal or greater cost in some other area"). *See also* Sloan & Conover, *supra* note 172.

[186] *See* T. Miller 6/25 at 64 (noting that mandates "can also have offsetting effects in terms of lower wages, decreased employment, reduced generosity of fringe benefits as well"). *See also* Gitterman 6/25 at 18; T. Miller 6/25 at 57.

[187] As the costs of mandates rise, more firms seek to self-insure to avoid the added expense of state mandates, but some smaller businesses do not have the necessary capital to do so. *See* Jensen & Morrisey, *supra* note 172, at 10. As stop-loss insurance with low attachment points has made self-insurance available on a broader basis, this problem has become less significant.

[188] *See* Kanwit 6/25 at 37; Gitterman 6/25 at 15 ("One of the things that you have seen in the 1996 mental health parity debate is the incredible wide range of estimates from each of these different consulting groups. I think the costs were somewhere between zero and 8 percent.").

[189] *See generally* 6/26 at 6-105; Hyman, *supra* note 177, at 234-36.

[190] The substantial tax subsidy for employment-based health insurance encourages broader and deeper insurance coverage than would otherwise be the case. Pauly 2/26 at 98; Clark Havighurst, *How the Health Care Revolution Fell Short*, 65 LAW & CONTEMP. PROBS. 55, 69-71 (2002).

[191] *See generally* Hyman, *supra* note 177.

[192] Michael Vita, *Regulatory Restrictions on Selective Contracting: An Empirical Analysis of 'Any Willing Provider' Regulations*, 20 J. HEALTH ECON. 955, 956 (2001).

[193] *See, e.g., id.* ("[F]reedom of choice (FOC) laws . . . obligate plans to reimburse for care obtained from a qualified provider even if the provider is not a member of the network")

health care providers.[194]

Commission staff has expressed concerns about AWP and FOC laws, noting that they could have anticompetitive effects and harm consumers.[195] These laws can make it more difficult for health insurers to negotiate discounts from providers in exchange for the higher patient volume that likely would result from restricted provider networks.[196] They can also limit competition, by restricting the ability of insurance companies to structure different plans with varying levels of choice in response to consumer demand.[197] These restrictions on competition may result in insurance companies paying higher fees to providers, which in turn generally results in higher premiums, and may increase the number of uninsured Americans.

As Commission staff explained in its most recent advocacy letter on this issue,

> Empirical evaluations of any willing provider and "freedom of choice" provisions indicate that these policies result in higher health care expenditures. One study found that states with highly restrictive any willing provider/freedom of choice laws spent approximately 2% more on healthcare than did states without such policies. This finding likely reflects the fact that these laws reduce the ability of insurers to offer less expensive plans with limited provider panels. This interpretation is supported by another study that found that metropolitan areas with a high intensity of any willing provider/freedom of choice regulation had HMO market shares approximately 7% lower than comparable areas without these provisions. "Freedom of choice" provisions reduced HMO market share more than any willing provider laws.[198]

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[194] *See, e.g., id.* ("By one count, 34 states had enacted some form of FOC or AWP law by 1996").

[195] *See* FTC staff comments on proposed legislation that incorporated any willing provider or "freedom of choice" provisions in the following states: Rhode Island (Letter from Office of Policy Planning et al., to Patrick C. Lynch, Attorney General (Apr. 8, 2004)), *at* http://www.ftc.gov/os/2004/04/ribills.pdf; Massachusetts (Letter from Bureau of Competition, to John C. Bartley, Representative (May 30, 1989)); New Hampshire (Letter from Office of Consumer & Competition Advocacy, to Paul J. Alfano (Mar. 17, 1992)); California (Letter from Office of Consumer & Competition Advocacy to Patrick Johnston, Senator (June 26, 1992)), *at* http://www.ftc.gov/opa/predawn/F93/calpharm.htm; Montana (Letter from Office of Consumer and Competition Advocacy, to Joseph P. Mazurek, Attorney General (Feb. 4, 1993)); New Jersey (Letter from Office of Consumer and Competition Advocacy, to E. Scott Garrett, Assemblyman (Mar. 29, 1993)); Pennsylvania (Letter from Office of Consumer and Competition Advocacy, to Roger Madigan, Senator (Apr. 19, 1993)); South Carolina (Letter from Office of Consumer and Competition Advocacy, to Thomas C. Alexander, Representative (May 10, 1993)); and Nevada (Letter from Bureau of Competition, to David A. Gates, Commissioner of Insurance (Nov. 5, 1986).

[196] *See, e.g.*, FTC Staff letter to Rhode Island, *supra* note 195, at 6; Greenberg 6/12 at 68-69.

[197] *See supra* note 196.

[198] FTC Staff letter to Rhode Island, *supra* note 195. *See also* Michael A. Morrisey & Robert L. Ohsfeldt, *Do State 'Any Willing Provider' and 'Freedom of Choice' Laws Affect HMO Market Share?*, 40 INQUIRY 362 (2003/2004).

Many provider groups support AWP and FOC legislation.[199] Commission staff observed in its most recent advocacy letter that "several scholars have noted that any willing provider and 'freedom of choice' laws are more likely to appear in states with limited managed care penetration, and suggested that these provisions are actually intended to preempt competition among providers [provider protection], instead of protecting the interest of patients."[200]

4. Potential Responses to the Demand for Mandated Benefits

As the number of mandated benefits has risen, sensitivity to their cost ramifications has increased. The Unfunded Mandates Reform Act discourages Congress from imposing unfunded mandates on other governmental entities.[201] The states have developed a variety of strategies to weigh the costs of mandated benefits, with varying degrees of success.[202]

There are four basic models for mandatory review processes: (1) use of an independent standing health care commission or legislative advisory commission/interim committee; (2) use of an administrative agency; (3) use of legislative research or fiscal staff; and (4) use of proponent prepared and submitted assessments to the legislative committee.[203] Each model has procedural variations in the review process including how the bills are referred for evaluation and the specific requirements of the impact analysis. Some of the models may be more credible and provide more objective information than others.

Conclusion. For mandates to improve the efficiency of the health insurance market, state and federal legislators must be able to identify services the insurance market is not currently covering for which consumers are willing to pay marginal cost. This task is challenging under the best of circumstances – and

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[199] *See, e.g.*, Gene A. Blumenreich, *United States Supreme Court upholds "any willing provider" statutes*, 71 AANA J. 259 (Aug. 2003) (Legal Brief of American Ass'n of Nurse Anesthetists), *at* http://www.aana.com/legal/legbrfs/2003/pdfs/p259-262.pdf; American Medical Ass'n, *H-285.984 Any Willing Provider Provisions and Laws* (AMA policy re: "Any Willing Provider" laws, including opposing federal preemption of state AWP laws), *at* http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/H-285.984.htm (last visited June 25, 2004); National Community Pharmacists Ass'n, *High Court Upholds State Any Willing Provider Laws* (from AMERICA'S PHARMACIST, May 2003), *at* http://www.ncpanet.org/leg_gov/notes_from_capitol_hill/2003/may.shtml

[200] FTC Staff letter to Rhode Island, *supra* note 195. *But see* Blumenreich, *supra* note 199 (noting that the American Association of Nurse Anesthetists (AANA) supports AWP legislation, arguing that these laws prohibit insurance companies from discriminating against them).

[201] CONGRESSIONAL BUDGET OFFICE, CBO'S ACTIVITIES UNDER THE UNFUNDED MANDATES REFORM ACT, 1996-2000 (2001), *available at* ftp://ftp.cbo.gov/28xx/doc2843/UMRA-Paper.pdf. Unfunded Mandates Reform Act (UMRA) of 1995, Pub. L. No. 104-4, 109 Stat. 48. The UMRA requires the Congressional Budget Office (CBO) to prepare an analysis of the direct costs of any mandates and an assessment of whether the bill authorizes or otherwise provides funding to cover the costs of the mandate.

[202] Gitterman & Nordyke, *supra* note 179.

[203] Gitterman 6/25 at 12-13.

JAN 1 3 2005

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January 10, 2005

David Wroten
Assistant EVP
Arkansas Medical Society
P.O. Box 55088
Little Rock, AR 72215

RE: **Cost of Any Willing Provider Legislation**

Dear Mr. Wroten:

This letter is in response to your request for information regarding the cost implications of Any Willing Provider ("AWP") legislation in Kentucky. As I stated in a previous e-mail to you, I researched the issue of cost while writing my Merits Brief for the United States Supreme Court and in preparation for oral argument before the Court. I was unable to find conclusive evidence that AWP legislation has increased cost for Kentucky insureds.

As part of my research, I consulted with our in-house actuary who informed me that he saw no increases in insurers' rate filings attributed to AWP. Although cost was irrelevant to the ERISA preemption argument made by the Kentucky Association of Health Plans, the health plans relied on the cost argument heavily during the six or more years of litigation on the issue. Therefore, I addressed the issue in footnote 7 of the Department's Merits Briefs (previously forwarded to you via e-mail).

The Robert Wood Johnson Foundation funded a study to determine the effects of Any Willing Provider Laws. The research team made preliminary findings that AWP laws had no affect on managed care plans "or the premiums paid by employers." See attachment 1. A follow-up to the Robert Wood Johnson Foundation study was done on the impact of AWP and Freedom of Choice Laws on HMO Market Share. (See attachment 2). I think it is interesting that Drs. Morrisey and Ohsfeldt question whether certain studies have overestimated the impact of AWP laws. (See pages 19-20, "If these estimates were accurate, one would have expected to see press reports of HMOs leaving

at least some states because of the enactment of the laws."). This observation is similar to the one made by Justice Ginsburg during oral argument in the KAHP v. Miller case. (Attachment 3, Justice Ginsburg pointing out that these laws have been around for some time). I could not find anything to substantiate the 15% increase in cost referred to by Mr. Eccles in his response to Justice Ginsburg.

In short, I have found no conclusive evidence that Kentucky's AWP laws have affected healthcare costs in this state.

Sincerely,

Elizabeth A. Johnson
Counsel

Attachments

DIRECTIVE: 2-2005

TO: ALL HEALTH MAINTENANCE ORGANIZATIONS, ACCIDENT AND HEALTH INSURANCE COMPANIES, ACCIDENT AND HEALTH INSURANCE AGENTS, THE ARKANSAS MEDICAL SOCIETY, THE ARKANSAS HOSPITAL ASSOCIATION, AND OTHER INTERESTED PARTIES

FROM: ARKANSAS INSURANCE DEPARTMENT

SUBJECT: ARKANSAS' "ANY WILLING PROVIDER" LAWS

DATE: JULY 15, 2005

The Department issues this Directive to advise all health maintenance organizations ("HMOs") and accident and health insurers conducting business in this state about compliance with Arkansas' Patient Protection Act of 1995 and recent "Any Willing Provider" ("AWP") legislation passed by the Arkansas State Legislature in 2005, in light of a recent decision by the 8th Circuit Court of Appeals ("8th Circuit") on June 29, 2005 in Prudential Insurance Co., et al. v. IMO Partners, Inc., et al., U.S.C.A. No. 04-1465/04-1644 ("Prudential II"). This decision will ultimately apply Arkansas' 1995 AWP Law to insured ERISA ("Employee Retirement Income Security Act") plans and non-ERISA health plans.

In 1995, the Arkansas State Legislature ("Legislature") enacted Acts 505 ("To Ensure Consumer Choice of Health Care Provider") and 1193 ("An Act To Assure The Gatekeeper System Is Preserved And Existing Contracts Are Not Impaired Under The Provisions Of The Patient Protection Act Of 1995"). These two Acts combined are the "The Patient Protection Act of 1995" ("1995 PPA") that required a health care insurer to accept a medical provider in the health insurer's medical network, if the provider agreed to the insurer's terms and conditions. However, before the 1995 PPA became effective, various parties successfully brought suit to prevent the Act's enforcement. Since its inception, the 1995 PPA has been before the courts and has never been enforced.

In 2005, the Legislature passed several new AWP statutes. Act 490 ("Patient Protection Act of 2005") provided a new AWP law designed to become effective only if the courts ultimately held the 1995 PPA invalid and preempted by ERISA in its entirety. Because the Eighth Circuit recently upheld the 1995 PPA, the 1995 PPA is the law, and Act 490 will not go into effect.

It is the Department's opinion that the remaining AWP legislation passed in the 2005 Legislative Session as Act 491 ("An Act To Provide For Enforcement Of The Patient Protection Act of 2005") and Act 960 ("An Act To Amend The Private Enforcement Provisions Of The Patient

Protection Act Of 1995 And The Patient Protection Act Of 2005") will become effective on August 12, 2005. The Department advises all HMO and accident and health insurers (as defined in Section 5(5) of Act 491 of 2005) to review and be expected to comply with the 1995 PPA, codified in Ark. Code Ann. §23-99-201, *et. seq.*, as amended by Acts 491 and 960 of 2005.

Health Benefit Plans Subject To The 1995 PPA As Amended This Legislative Session

In Prudential II, the 8th Circuit explained that the 1995 PPA was a state law saved from preemption by ERISA to the extent that the law "regulated insurance" and was aimed at "entities engaged in insurance" or the "insurance industry." The Court concluded that AWP applied to "non-ERISA health plans" and "insured ERISA plans." However, because "self-funded" ERISA health plans were not "insured," AWP was preempted to the extent it applied to a self-funded ERISA health plan. The Department therefore advises that it intends to apply AWP to all fully-insured health benefit plans: insured by group and individual accident and health policies, health maintenance organization contracts, hospital and medical service contracts, and any other "health benefit plan" defined in Act 491 of 2005.

Generally, health benefit plans that are not subject to AWP include *self-funded* employer plans, even if the health plan hires an insurance company to administer plan benefits or pays for access to a health insurer's provider network.

After reviewing the decision in Prudential II and the 1995 PPA, as amended by Acts 491 and 960 of 2005, the Department describes types of group health benefit plans most common in Arkansas to further clarify the application of AWP to health benefit plans:

1. Insured ERISA plans. These health benefit plans are fully subject to the 1995 PPA, as amended, and provider networks used by them must be AWP-compliant. This is true even if a "non-insurer" (as defined in Section 5(6) of Act 491) provides the plan with a network of medical providers. In other words, with regard to insured plans, the ultimate responsibility for compliance with AWP rests with the health insurer. [Act 491, Section 4(d)(4)].

2. Self-funded ERISA plans. Prudential II holds that self-funded ERISA plans are AWP-exempt, and that the 1995 PPA, as amended, cannot be used to directly or indirectly regulate the operations of self-funded ERISA plans.

3. Self-funded *non*-ERISA health benefit programs. There exist group health benefit plans which are not subject to the ERISA statutory regime, including but not limited to governmental health benefit plans and church plans. These *non*-ERISA plans are subject to the 1995 PPA unless (1) they are self-funded and (2) contract directly with a "non-insurer" (such as a typical Physician Hospital Organization, Independent Practice Association, or third-party administrator) to provide the plan with a network of medical providers, under Section 4(d)(1) and (2) of Act

491 of 2005. Please note however that if a non-ERISA plan, whether self-funded or insured, arranges with a health insurer to provide the plan with a network of medical providers, the plan is subject to the 1995 PPA as amended. Again, this paragraph applies in the unique circumstances of *non*-ERISA plans. Most group plans, whether self-funded or insured, are ERISA plans.

4. Arkansas State Employees Health Benefit Plan. It is the Department's position that because the state employee's health plan is a self-funded *non*-ERISA health plan that has not contracted with a "non-insurer" for a provider network, the health plan is subject to AWP. It is the Department's position that any self-funded governmental or church health benefit plan which has contracted with an insurer to provide the plan with a network of medical providers is a non-ERISA plan subject to AWP, for the reasons explained in paragraph 3. Any insured *non*-ERISA plan is subject to AWP.

5. Workers' Compensation Health Benefits. After researching the historical definition of a "health benefit plan" in the 1995 PPA, which excepted AWP from applying to workers compensation benefits, and researching the legislative intent behind recent changes to the definition of "health benefit plan," the Department's position is that AWP was not intended to apply to workers' compensation health benefits. Workers' Compensation was excluded from application of AWP in 1995, and the structure and nature of the medical compensation itself derives from liability insurance, rather than health insurance.

Health Care Providers Entitled To Any Willing Provider Rights

Medical providers entitled to request AWP access are listed in Act 491 of 2005. AWP access is not restricted to licensed physicians. Other providers are entitled to request AWP access, and these include podiatrists, chiropractors, physical therapists, speech pathologists, audiologists, dentists, optometrists, hospitals, psychologists, licensed professional counselors, respiratory therapists, pharmacists, occupational therapists, long-term care facilities, home health care providers, hospice care providers, licensed ambulatory surgery centers, rural health clinics, licensed certified social workers, licensed psychological examiners, advanced practice nurses, licensed dieticians, community mental health centers or clinics, certified orthotists, prosthetists, licensed durable medical equipment providers, and other medical providers determined by regulations of the Insurance Department. At this time, the Department has not promulgated any rule expanding or modifying the list of medical providers entitled to request AWP access. There is no requirement in the AWP laws to provide coverage of any particular health care service. If the service of a particular class of providers (e.g., chiropractors, dieticians, hospice, etc.) is included in the health benefit plan, then all providers in that same class who qualify for membership are eligible to be part of the plan's network. (Ark. Code Ann. §§ 23-99-204(b) and 205; Act 491, Section 4(c)(1)).

The Department advises health care insurers to pay particular attention to the fact that hospital services are included in AWP in the definition of "health care provider" in Act 491 of 2005; therefore, hospitals that agree to the terms and conditions of the health care plan are entitled to AWP access and rights with health care insurers.

Health Care Provider Requests For Network Access

AWP does not describe the mechanics and timing of health care provider requests for network access with the health care insurer. Providers interested in being admitted into a network should contact the insurer or HMO for an application. The Department advises every HMO and accident and health insurer to promptly give providers a written application and a description in writing of the application process for each medical provider requesting network access with the health care insurer. In addition, the health care insurer should provide a written description of the health care insurer's terms and conditions, schedule of fees, covered expenses, and utilization regulations and quality standards. Ark. Code Ann. §23-99-204(3). Act 491 of 2005 requires that the health care insurer "apply such terms and conditions in a nondiscriminatory manner." The Department advises that every health care insurer should follow Ark. Code Ann. §23-99-411 and take no longer than 180 days to process completed applications from medical providers.

Restriction On Health Care Provider Discrimination

Arkansas law prohibits health care insurers from imposing any monetary advantage, penalty, or higher copayment under a health benefit plan that would affect a beneficiary's choice of health care providers. Health care insurers should abide by the "non-discrimination" requirements on health care providers in Ark. Code Ann. §23-99-204. AWP prohibits the imposition upon a beneficiary of a health care service any copayment, fee or condition that is not equally imposed on all beneficiaries in the same benefit category, class, or copayment level when the beneficiary is receiving services from a participating health care provider under the health benefit plan. However, the law does not prohibit varying the level of co-payment, fee or condition as between provider types. Also, it is the Department's position that the above requirements only apply to health care providers who have agreed to the terms and conditions of the health benefit plan in Ark. Code Ann. §23-99-204(a)(3).

For questions regarding this Directive, please contact the Legal Division of the Arkansas Insurance Department, 501-371-2820.

(Signed by Julie Benafield Bowman) (July 15, 2005)

JULIE BENAFIELD BOWMAN
INSURANCE COMMISSIONER
STATE OF ARKANSAS

DATE

NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

Analysis of State-Level Health Insurance Market Reforms

October 2003

The National Association of Health Underwriters (NAHU) is a trade association that represents approximately 20,000 health insurance producers and employee benefit specialists nationally. Our members service the health insurance needs of millions of Americans. As an association of health insurance professionals, NAHU's two top public policy objectives are: (1) reducing the number of uninsured Americans through private-market solutions, and (2) making sure that state-level private health insurance markets are as vibrant and competitive as possible.

NAHU recognizes that state health insurance markets are both extremely diverse and complex. Certainly, market reforms that work well in one state might not work as effectively in another. Furthermore, no one state has what could be termed the perfect health insurance climate. However, the fact remains that some state health insurance markets work much more efficiently than others—more carriers compete in these markets, costs are lower and there are fewer uninsured. This paper will identify some of the key elements of successful health insurance markets, explain why these reforms are important, and give examples of why some state health insurance markets work, and why others have failed.

Key Components to Health Insurance Market Stability

Ability to Medically Underwrite in the Individual and Small-Group Markets

One of the most important characteristics of a successful state health insurance market is the ability for health insurers to accurately assess risk for policies sold to both individuals and small businesses. Health insurance is a risk management mechanism and the level of risk varies amongst the insured population. The price of health insurance must reflect these differences in risk, because if everyone paid the same amount for health insurance, only those with the greatest need for expensive medical care would purchase coverage, thereby creating a dysfunctional health insurance market.

The way carriers can accurately assess individual market and small-group risks is through the practice known as medical underwriting. In states that allow for this, each individual applicant or employee is required to complete an individual questionnaire with detailed health information on the employee and all family members to be covered. The underwriter normally uses only information obtained from the application, but sometimes the underwriter will request additional information from an applicant's physician or may telephone the applicant to clarify an item on the application. If an underwriter is unable

to obtain information necessary to accurately determine the risk of a particular applicant, he or she will underwrite more conservatively, meaning that the assumption relative to the missing information will be negative rather than positive. So, for example, if an underwriter sees that a person has a history of high blood pressure that is controlled with medication and has a weight within normal limits, but he or she is unable to determine whether or not the individual smokes and has a normal cholesterol level, the underwriter will assume that the missing information is negative.

All states but nine[1] allow for medical underwriting in the individual market, however, only 37 states[2] allow for medical underwriting in the small-group market. The ability of insurers to accurately assess risk is extremely important, particularly in markets such as the individual and small group markets where the ability to spread risk is limited, and is even more important in states that allow for self-employed individuals to qualify as business groups of one.

The most common type of state small-group rating law[3] allows groups to be rated 25 percent above or 25 percent below an "indexed" rate. The indexed rate is determined by averaging the lowest possible rate and the highest possible rate. Most states that have this type of rating system also have a limit on rate increases due to the health status of the group, which is helpful in stabilizing rates over time. Even with these initial rate fluctuations for a new group, small employer rates in these states tend to be much lower than in states where health status rating is not allowed. A group that is rated correctly up front is much less likely to have a very large increase at renewal, and in order to rate the group correctly, the correct information on the initial application is essential.

The alternative to medical underwriting is community rating or a modified form of this rating mechanism. Certain states employ the community rating mechanism, which requires insurers to charge all individuals who live in the same zip code the same exact premium regardless of their age or health status. So, for example, in a community-rated state, an employer would pay the same amount per month to insure a healthy 27-year old non-smoking male with no health conditions as it would to insure a 55-year old male smoker who is suffering from prostate cancer and a heart condition, simply because the two live in the same zip code.

A variation on this rating mechanism is known as modified community rating. In states that use this mechanism, health plans are allowed to vary the community rate based on limited factors, such as age, gender and/or smoker status. So, for example, in a state that

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[1] Maine, Massachusetts, New Jersey, New Mexico, New York, North Dakota, Oregon, Vermont and Washington all either require community rating or modified community rating in their individual health insurance markets.

[2] Arizona, Colorado, Connecticut, Florida, Maine, Maryland, Massachusetts, New Jersey, New Mexico, Oregon, Vermont and Washington all allow for either modified community rating or community rating in their group markets. However, Colorado will begin to allow for rate flexibility in the small group market in 2004.

[3] Fourteen states allow for small-group rate bands of +/- 25 percent. The other remaining 23 states either allow for rate bands that range from 10-55 percent, or allow for medical underwriting without rate bands in the small-group market.

allows modified community rating with variations for age, an insurer could charge more for the 55-year old male smoker with cancer and a heart condition than for the 27-year old healthy male. However, the insurer would have to use the same rate when calculating premiums for the healthy 27-year old male as it would for a male co-worker who is the same age but suffers from juvenile diabetes. Also, it is important to note that state-level modified community rating laws vary greatly. Some allow for many adjustment factors, but many allow for just a limited few, such as gender, age and family composition only. Modified community rating has a severely negative impact on health insurance rates in all states that employ the mechanism, but the more limited the rate adjustment factors, the more severe the problem.

NAHU has observed that in all states with the community rating and modified community rating mechanisms, younger healthier individuals and workers are penalized since carriers cannot account accurately for these healthy risks. This leads to much higher overall health insurance rates than in the states that allow for the use of medical underwriting in the individual and small-group markets. In addition, since these laws make it much more difficult for health insurers to rate their products accurately, doing business in states with these requirements is much more costly. As such, fewer health insurers may offer plan options in these states, which in turn limits consumer choice, reduces competition and leads to overall price increases.

Appropriate Group Size Definitions

How states define and divide their health insurance markets also has a strong impact on market stability. State health insurance markets are generally divided into three categories—the individual, small-group and large-group markets. Individual markets serve people who for some reason do not have access to employer-sponsored health insurance coverage. In almost every state, the small-group health insurance market serves employer groups with less than 50 employees. The majority of states define an employer group as at least two individuals, but 14 states allow for self-employed individuals to be considered a business group of one. Large-groups are typically defined as employer groups that have more than 50 employees.

In studying state-level health insurance markets nationally, NAHU has found that the most successful states define their group markets as follows—small-groups as 2 to 50 employees, and large-groups as 51 employees and above. The states that allow for business groups of one typically have much higher overall small-group rates for a variety of reasons. First of all, the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health insurance be guaranteed issue for all employer groups. This is a requirement that only three of the 14 states place on their individual market carriers[4]. Guaranteed issue in the individual market and for groups of one has historically been a problem, because in a group of one, there is absolutely no means for an insurer to

[4] The three states that allow for business groups of one and mandate that all insurers in the individual market guarantee issue coverage to all individuals are Maine, New York and Vermont. In three other states, Hawaii, Michigan and Massachusetts, Blue Cross/Blue Shield currently serves as the guaranteed issue carrier of last resort for the individual market.

spread risk. If an insurer has to cover all individuals who make up groups of one regardless of any medical conditions, then the insurer is forced to assume that each of these one-person groups is a medical risk, and rate all small-group products accordingly. In addition, in the nine states (Colorado, Connecticut, Delaware, Florida, Hawaii, Maryland, Michigan, Mississippi and North Carolina) that permit medical underwriting in the individual market, the laws create a perverse incentive for individuals with serious medical conditions to try and "game" the system and attempt to obtain guaranteed issue group coverage as a business group of one, even if they do not operate legitimate businesses. This is known as "adverse selection," which inevitably leads to higher rates for all individuals in the small-group market.

High-Risk Health Insurance Pools

NAHU has found that another key component to health insurance market stability in a state is the existence of a well-functioning, appropriately funded, health insurance high-risk pool for medically uninsurable and HIPAA-eligible individuals. High-risk health insurance pools have been created in 32 states[5] in order to provide affordable and quality private health insurance options for individuals with catastrophic medical conditions who do not have access to the group insurance market. The vast majority of these states also use these pools as an alternative mechanism to the guaranteed group-to-individual health insurance portability provisions required by HIPAA.

Risk-pool consumers are often self-employed individuals, early retirees or employees of small businesses that do not offer benefits. They generally have very serious preexisting medical conditions, such as cancer, diabetes, or another chronic illness that would cause them to be turned down if they applied for traditional private-market individual insurance. For most people who buy coverage in these pools, the risk-pool is an intermediate coverage solution. The average amount of time an individual spends in a risk-pool is 30 months, since many individuals eventually obtain group coverage or qualify for Medicare or another government-sponsored health insurance program.

High-risk health insurance pools help stabilize insurance markets, because they allow insurers to segment the severely unhealthy people seeking individual coverage, but still offer these individuals access to private market coverage. Consumers that need to purchase coverage in the high-risk-pool have access to comprehensive private-market coverage options that might not otherwise be available to them. These individuals pay higher rates than other individual market consumers, but these rates are capped, generally at about 125-200 percent of the average individual market rate. This arrangement benefits both consumers and insurers. Consumers are provided with a very important safety net, and insurers are provided with a predictable means of accounting for uninsurable risks. This allows individual market carriers to keep rates much lower for all

[5] The states that have created health insurance high-risk pools are: Alabama, Alaska, Arkansas, California, Colorado, Connecticut, Florida, Idaho, Illinois, Indiana, Idaho, Iowa, Kansas, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, Wisconsin, and Wyoming.

traditional consumers, and since state laws cap risk-pool participant premiums based on the average individual market rate, the high-risk consumers also significantly benefit from these lower rates. Furthermore, small-group health insurance carriers and consumers also greatly benefit from stable high risk-pools, since the availability of a risk-pool in a state significantly decreases the risk that a person with a serious medical condition will try and "game" the system and obtain guaranteed issue group coverage. This, in turn, helps keep small-group rates in the state much lower.

In addition to the existence of a high-risk health insurance pool, stable funding for the pool is crucial. State risk-pool rates are capped, and because the individuals that utilize the pool often have the highest possible loss ratios, premiums alone would never be sufficient to satisfy claims. Therefore, the 32 states that have created high-risk pools to serve their individual health insurance markets have also established additional funding mechanisms to offset pool losses. State funding sources for high-risk pools range from legislative appropriations, to tobacco settlement funds, to hospital use surcharges. The most common funding source is some type of assessment levied on health insurance carriers in the state. While NAHU favors a specific type of carrier assessments for offsetting risk-pool losses, our organization has found that the most important item necessary in creating a successful risk-pool is selecting a stable funding source.

Examples of states that have had problems with pool funding instability in the past include California, Florida, Illinois, and Louisiana. All of these states have had to either limit enrollment, implement waiting lists, reduce services and/or close their pools, in order to deal with funding shortfalls. In addition, due to the current status of many state budgets, states that use funding mechanisms like appropriations, tobacco settlement revenues and assessments with premium tax credit offsets, such as Utah, Kentucky and Arkansas, respectively, have indicated that they are likely to encounter funding troubles in the future.

File and Use vs. File and Approve

NAHU has also found that state regulations regarding the filing of health insurance rates also have an important impact on market stability, especially in the individual and small-group markets. In most states, insurers are permitted to simply file their rates with the state insurance departments and then immediately be able to "use" them. However, in some states, insurers are required to submit their rates to the state department of insurance for approval prior to use. This can be problematic, especially in the individual market, where rates are more volatile, due to the inability of health insurance carriers to spread risk. Rate increases in "file and approve" states tend to be higher than in "file and use" states because carriers have to build in reserve funds for every rate increase request, to compensate for the possibility of future rate change denials. In addition, "file and approve" requirements can hinder carriers from bringing new insurance products into the market in a timely basis, which also hurts consumers, since it can limit choice in health products.

Limits on Mandated Benefit Laws

Another important component of a stable state health insurance market is a limited number of health insurance mandated benefit requirements. In recent years, the number of mandated benefit laws, or laws that place requirements on the content of private health benefit plan contracts, have increased significantly. Mandate laws range from statutes that require health plans to cover services by particular types of providers (e.g., chiropractors, optometrists), requirements to cover specific diagnostic or treatment services (e.g., mammography, infertility) or laws to extend certain benefits to certain populations (e.g., continuation coverage of employees or health plan liability). While individual mandates are often very popular since they are intended to provide specific populations with greater access to particular services, there is a cumulative price tag associated with ensuring such access. The sheer volume of mandated benefit laws being passed in the states has caused health insurance premiums to rise substantially. Research shows that there are now over 1000 benefit mandates in existence, and various studies indicate that they have caused health insurance premiums to increase as much as 25 percent[6]. Therefore, an increase in the number of mandates that are imposed leads to more people being priced out of health insurance, further swelling the ranks of the uninsured. A large number of health insurance mandates hits the small-group and individual health insurance markets particularly hard, since larger employer groups are more likely to self-insure, thus exempting them from state-level mandated benefit laws, as provided by the federal Employee Income Retirement Security Act of 1974 (ERISA).

Certain states, like Maryland (57 state mandated benefit requirements) and Connecticut (49 state mandated benefit requirements)[7], lead the pack when it comes to mandates. However, in recent years, many states have taken action to curb state-level mandated benefit requirements, as one way to keep health insurance costs under control. States have taken various approaches to this task. Virginia, for example, with 47, has a very high number of mandated benefit requirements. However, six of those mandated benefit requirements, including some of the more expensive mandates, like morbid obesity treatment and bone marrow transplants, are mandatory offer laws.[8] This means that employers and individuals only have to be given the option of choosing policies that include those benefits. This can substantially reduce costs for employers and individuals, since they do not have to select the benefits that do not meet their individual needs. Twenty-five states[9] have requirements that all mandated benefit proposals go through some type of cost-evaluation before enactment. However, in only five of those states, Maryland, Pennsylvania, South Carolina, Virginia and Washington, are those cost review impact studies mandatory and completed on a regular basis. Finally, a few states, like

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[6] Source: Jensen, G. and Morrissey, M. "Mandated Benefits Laws and Employer-Sponsored Health Insurance." Health Insurance Association of America, January, 1999.

[7] Source: Blue Cross Blue Shield Association. "State Legislative Health Care and Insurance Issues; 2001 Survey of Plans." January 2001.

[8] Ibid.

[9] Arizona, Arkansas, Colorado, Florida, Georgia, Hawaii, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Nevada, New Jersey, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington and Wisconsin are the states with mandated benefit evaluation laws.

Louisiana, North Carolina and Oregon, have passed legislation in recent years limiting the number new mandates that can be enacted, due to the impact those mandates have on health insurance costs in the states.

Appropriate Regulation of Managed Care Carriers

While the problem of appropriate regulation of managed care carriers has only arisen in a few states, it can be a very serious impediment to market stability. The vast majority of states make the appropriate distinction in their laws between health maintenance organizations (HMOs) other types of managed care health insurance products, such as preferred provider organization (PPOs). HMOs exercise a great deal of control over the health care treatment of their policyholders, while PPOs typically do not strictly control the medical treatment of policyholders. However in a few states, like Rhode Island, all managed care insurance companies, including both PPOs and HMOs, are considered "health insurance issuers" without any regard to the particular products they offer in the marketplace. The result is that all of the operations of the insurance company, including non-HMO products, become subject to the requirements of the state's HMO law.

Unlike HMOs, PPOs simply make decisions concerning the reimbursement of health care expenses of policyholders based upon the insurance contract. Additionally, PPOs do not use a gatekeeper or require referrals from a primary care physician in order to see a specialist. However, in states where PPOs are subject to all HMO requirements, these plans can be forced to implement very expensive and unnecessary reforms, such as hiring a full-time medical director. NAHU has found that placing additional regulation on entities that only finance health care services creates additional financial burdens on these companies without any benefit to consumers. The result has been massive carrier withdrawal from these states. For example, Rhode Island is down to one individual market insurer, two small-group insurers, and four large-group insurers.

Ability of Plans to Develop Appropriate Networks

Another important characteristic of a successful state health insurance market is the ability of health insurance plans to be able to develop strong networks of providers, and to be able to effectively negotiate discounts with those providers. This is critical for both health insurance plans and health insurance consumers, since plans need to be able to negotiate with a wide range of quality providers in order to both attract customers and to keep costs low, and consumers benefit from having a wide range of doctors from with which to choose.

Several states have enacted measures that make it difficult for plans to develop a comprehensive and effective network of providers. For example, a number of states require health plans to accept any willing provider who meets their plan criteria into their networks. The vast majority of these states limit these measures, so that they, for example, only apply to pharmacies. However, Idaho and Kentucky extend these requirements to all providers. Any willing provider mandates may seem like they would benefit consumers, since they allow the greatest number of providers into a plan, but

these laws actually have a serious negative consequence. Since any doctor who wishes to participate with a plan can, it makes it much harder for carriers to negotiate any discounts with providers, since there is no financial consequence for non-participation. This leads to higher medical reimbursement costs for all plans in the states, which translates into higher insurance rates for consumers.

Another way states can limit a health plan's ability to negotiate with providers is through the passage of an antitrust exemption for physicians in a state. Currently, when doctors and other healthcare providers negotiate their contracts for services rendered with health benefit plans, they must abide by state and federal antitrust laws that prohibit them from engaging in collective bargaining. However, legislation has been passed in Alaska, New Jersey and Texas that gives physicians and other health care professionals immunity from those antitrust laws and allows them to bargain collectively according to the same rules that apply to organized labor groups who are governed by the federal National Labor Relations Act.

Competition keeps healthcare costs down in the private sector, as well as in the Medicare and Medicaid programs, and these antitrust laws help eliminate competition amongst healthcare professionals by permitting them to engage in price-fixing, boycotts and market allocation agreements that would otherwise be illegal under the antitrust laws. Advocates for these measures have claimed that they are necessary to help providers protect consumers, but that is not really the case. Antitrust waivers are needed to enable providers to collectively discuss health plans issues involving legitimate quality-of-care concerns or bring such issues to the attention of the public. The 1996 Department of Justice/Federal Trade Commission guidelines state that such discussions are permitted under the current antitrust laws as long as they do not involve boycotts or other collective activity that could limit the choices available to consumers. The reality is that these measures are simply a means for providers to band together to negotiate higher fees, which only hurts health plan consumers by increasing health insurance rates.

Allow For the Widespread Availability of Different Plan Choices

Perhaps the most important element of a successful state health insurance market is the availability of a wide variety of plan options for consumers to choose from. Competition lowers prices, and with many competitively priced plan options out there, less people will go uninsured. States can help ensure that individuals have a wide array of plan options by implementing laws that allow for the introduction of innovative products in their markets, such as medical saving accounts. But the most important thing a state can do to ensure a greater degree of consumer choice is to make sure that the state maintains a regulatory and legislative environment that encourages many health insurance carriers to actively market products in the state.

Accurately tracking the number of health insurance carriers actively marketing in a state can be problematic, since HIPAA requires a five-year ban on reentry for all carriers that officially withdrawal from a state health insurance market. As a result, many carriers get around this requirement by simply limiting their marketing efforts, or by only servicing

current policyholders. As such, state insurance department records of the number of health insurance carriers in a state are not always precise.

However, NAHU has found a high degree of correlation between the states that do not always follow the criteria listed in this paper for successful health insurance markets and states where health insurance producers report a high rate of insurance carrier exodus. Furthermore, in these states we also have seen evidence of higher rates, and higher number of uninsured individuals. As such, NAHU strongly recommends that states allow for the use of medical underwriting in the small-group and individual markets, prohibit business groups of one, create high-risk pools, allow rates to be filed and then immediately used, limit the number of mandated benefit requirements, regulate PPO plans appropriately, and allow for the development of effective plan networks. This will keep health insurance rates down, the level of competition high, and the number of uninsured as low as possible.

Examples of State Markets That Work

Virginia

The Commonwealth of Virginia is one of the more attractive environments for health insurance carriers to do business in the United States, for several reasons. First of all, in Virginia, health insurance carriers are able to fully underwrite both individuals and small employer groups based on medical history. Furthermore, the definition of a small employer for the purposes of obtaining health insurance is one that employs between two and 50 individuals, and the state maintains tight controls to ensure that qualifying businesses are legitimate and actually employ at least two people.

Virginia does not have a high-risk health insurance pool for medically uninsurable people in the individual market, but Anthem Blue Cross/Blue Shield, the largest health insurance carrier, serves as the carrier of last resort for people with catastrophic health conditions, in exchange for tax advantages from the Commonwealth. As such, Anthem essentially functions as a private high-risk pool, and all of the state's other individual market carriers derive similar benefits from Anthem's actions as they would if Virginia had a traditional high-risk pool in place. Furthermore, Virginia's small-group market benefits from the individual market stability, just as it would if a risk-pool were in existence. As a result, for the size of the state, there are a large number of carriers competing in the market place, rates are relatively low for individuals and businesses, and only 12 percent of the state's population goes without health insurance, compared with the 14.7 percent national average.[10]

This is not to say that Virginia's health insurance market is entirely problem-free. Health insurance rates in Virginia have climbed in recent years, just as they have nationwide. The difference is, though, that cost increases in Virginia can primarily be attributed to overall rising medical costs, instead of rising medical costs combined with regulatory

[10] Source: U.S. Census Bureau. *Health Insurance Coverage: 2002.* "Table 4. Percentage of People Without Health Insurance Coverage for the Entire Year by State (Three-Year Average): 2000 to 2002."

costs and lack of competition, as is the case in many states. Also, the number of mandated benefit laws in Virginia remains very high, but as explained earlier in this paper, a number of the most expensive mandates are "mandatory offer" requirements, as opposed to "mandatory inclusion," and the state has one of the few effective mandate evaluation boards operating in the country.

Illinois

Another state with a very stable health insurance market is Illinois. Carriers in Illinois are not subject to any rating restrictions in the individual market, and in the small-employer market, carriers can medically underwrite their products as long as they stay within rate bands of plus or minus 25 percent. The small-group health insurance market serves employers with between 2-50 employees, and the state has a moderate number of health insurance mandated benefit requirements, with 32 mandates currently on the books. Perhaps the most important facet of Illinois' market stability is the regulatory climate it provides to health insurance plans in the state. Illinois not only allows for the "file and use" of health insurance rates, but the state has also been cited by several major insurance carriers as providing one of the friendliest regulatory environments to carriers in the country, which helps make plans want to do business in the state. As a result, the market is extremely competitive, and consumers in Illinois benefit from the correspondingly low health insurance rates.

One area where Illinois could stand some improvement concerns its high-risk health insurance pool. The pool has been serving high-risk people in the individual market since 1989, and is in many ways extremely effective. However, Illinois splits the way it funds losses incurred by its risk-pool. Losses for traditionally medically uninsurable individuals are funded by direct appropriations from the state, whereas losses for HIPAA-eligible individuals who enter the pool exercising their guarantee-issue rights are funded by assessments on health insurance carriers in the state. As a result, the HIPAA-eligible portion of the pool has always had a stable source of funding, but the medically uninsurable portion of the pool has faced periodic challenges. In order to meet funding restrictions, Illinois has had to impose a cap on enrollment for medically uninsurable people, and this has sometimes caused the state to have to implement a waiting list for pool coverage. NAHU feels that the medically uninsurable component of the risk pool in Illinois would greatly benefit from a more stable funding source, and it is our hope that the recent availability of federal funding for state high-risk pools will help spur a legislative change in the state to create a more stable funding base for this segment of the pool.

Examples of State Markets That Are In Trouble

Rhode Island

The private health insurance market in Rhode Island is on the verge of collapse. In 2001 and 2002, the state witnessed a number of carriers leave both the individual and small-group health insurance markets. According to the state Department of Business Regulation's Division of Insurance, currently, only one carrier is actively marketing policies in the individual market and one carrier is merely servicing existing

policyholders. In the small-group market, two carriers are actively marketing policies, and for large-groups, there are four carrier options available. In NAHU's view, several factors have contributed to this state's carrier exodus.

First of all, the state does not make a regulatory distinction between HMOs and PPOs. As such, all carriers who operate PPO plans and serve more than 1,000 policyholders in the individual market and more than 10,000 policyholders in the small-group market are required to follow all of the same very stringent and expensive regulatory requirements of an HMO plan. Since PPO plans, due to their structural differences, are generally much less expensive than HMO plans to operate, this regulatory environment has made it cost-prohibitive for most carriers to offer PPO products in the state. Those that do offer PPO products are faced with a perverse disincentive to grow their customer base beyond 1,000 lives in the individual market and beyond 10,000 lives in the small-group market, as doing so would significantly increase costs beyond the profitability level.

Some other problems in the state include the lack of a permanent option for medically uninsurable individuals in the individual market, and a "file and approve" requirement for all health insurance rates. Currently, Blue Cross and Blue Shield of Rhode Island, which is the only carrier actively marketing an individual product in the state, voluntarily offers guaranteed issue coverage to people seeking coverage in the individual market, regardless of health condition. However, the individual product this carrier offers has limited major medical benefits, and high-risk individuals can exceed the maximum benefit in rather short order. As a result, many Rhode Island residents with catastrophic medical conditions who do not have access to group coverage are currently uninsured, and have no legitimate options for obtaining private coverage. Rhode Island's "file and approve" requirement for health insurance rates has also been cited by several health insurance carriers as an impediment to doing business in the state, since the requirement restricts carriers ability to adjust rates based on economic and market changes, and it can also hinder the ability of carriers to bring new products to market in a timely fashion.

Finally, legislation that was enacted several years ago and is slated to go into effect in 2005 may make it difficult to attract new health insurance carriers to the state. The state currently defines a small-employer group as 2-50 employees. However, beginning in October of 2005, the definition of a small group for the purposes of health insurance will be changed so that business groups of one will be eligible for guaranteed issue group health insurance. When combined with the competitive hurdles that already exist for health insurance carriers in this state, these forthcoming reforms have prevented any new health insurance carriers from entering this market since the carrier exodus began in 2001.

Florida

The private health insurance market in Florida has been on the decline for some time. And while a variety of factors have contributed to this decline, the most significant factor, in NAHU's view, is the state's lack of a mechanism for providing coverage to medically uninsurable people in the individual market. Florida technically has a high-risk health insurance pool in existence, but the pool has been closed to new applicants for the past

eleven years due to funding woes. Since there is no adequately functioning risk-pool, the state requires that all individual carriers guarantee issue coverage to individuals exercising their HIPAA group-to-individual portability rights, at great expense. For people seeking private individual market health insurance coverage who are not HIPAA-eligible and are declined for coverage due to health conditions, there are no legitimate options available.

This lack of a high-risk pool has caused serious repercussions in the state's individual market, as well as in the small-group market. No means of covering individuals with serious medical conditions other than the group market would be problematic in any state, but it is particularly troubling in Florida, where the warm climate attracts a huge number of early retirees. Early retirees frequently do not have access to group medical insurance benefits, and they are also disproportionately likely to have one or more medical conditions that would hinder their ability to qualify for traditional medically-underwritten individual health insurance.

Since carriers are forced to take HIPAA-eligibles on a guaranteed issue basis, participating in the Florida health insurance market is particularly expensive. Many carriers attempt to make up for large HIPAA-eligible losses by imposing particularly strict medical underwriting criteria on the rest of the individual market. Many other carriers deemed it too expensive to write traditional individual insurance in the state, and instead until recently operated in the market in a limited fashion under the state's out-of-state-group law. This peculiarity in Florida state law was changed during the 2003 legislative session, but it had allowed non-domiciled carriers to sell products in the state under limited regulation by the state Department of Financial Services. This loop-hole had allowed the state's individual market to stay relatively competitive under adverse market conditions, but it also led to some carrier abuses like the use of re-underwriting in the individual market, as well as in a proliferation of sham health plans being marketed in the state. While NAHU feels that a level playing field is essential for a competitive health insurance market, and that closing this loophole was necessary for appropriate market regulation, it's existence did help mask the state's individual market problems. Now that it is closed, it remains to be seen how the state's individual market will react.

The Florida small group market is, in many ways, in even worse shape. Florida allows for the sale of guaranteed issue group coverage to one-life groups. And since there is no functioning risk-pool many people with serious medical problems who can't obtain individual coverage seek to obtain coverage through the individual market by claiming to be self-employed The result has been the creation of hundreds of thousands of one-life groups in Florida over the past few years, and the high loss-ratios associated with these groups have caused rates for the entire small-group market to skyrocket.

To further complicate the problem, Florida does not allow for true medical underwriting in their small-group market. Instead, Florida utilizes the modified community rating mechanism. Reforms enacted in 2000 enabled insurers to use health status on a very limited basis as one of the factors allowed in determining rates, but this is not the same as allowing complete medical underwriting, and thus has not had the desired effect on rates.

During the 2002 legislative session, a measure was passed that allows one-life groups to be segmented from the rest of the small-group market and rated separately, but it remains to be seen what impact, if any this will have on overall small-group rates.

Examples of States on the Rebound

New Hampshire

In 1995, the New Hampshire health insurance market was relatively healthy and competitive, with 34 carriers offering health insurance products. However, reforms enacted in the 1990s eliminated the use of medical underwriting in the state and required that individual market health insurance products, as well as group health insurance products, be offered on a guaranteed issue basis. Furthermore, for many years New Hampshire was the only state in the nation that defined a small employer for the purpose of providing health insurance as an entity that employs between 1-100 individuals. As a result, the state's health insurance market began to rapidly deteriorate and costs began to rise, so that by 2000, the state was down to five carriers offering health insurance products, with two of those carriers dominating 90 percent of the small-employer market.

During the 2001 legislative session, members of the New Hampshire Association of Health Underwriters worked with legislators, health insurance carriers, business groups and other insurance agent trade associations on reform measures to repair the state's private health insurance market. This effort was largely successful, and legislation was passed that eliminated the guaranteed issue requirement for individual market health insurance, allowed for the use of medical underwriting, and created a high-risk health insurance pool, amongst other changes. Based on these legislative changes, one very large insurance carrier immediately agreed to re-enter the New Hampshire individual and small group markets, and subsequently, since the risk-pool has become operational, several other carriers have begun to market new products in New Hampshire, and costs are already beginning to drop.

During the 2003 legislative session, the New Hampshire Association of Health Underwriters and many coalition partners tackled the state's small group health insurance market laws and again they were very successful in getting market-friendly changes passed into law. The legislation passed in the spring of 2003 changed the size of a small employer group in New Hampshire for health insurance purposes from 1-100 employees to 2-50 employees, bringing New Hampshire in line with national standards. Furthermore, the new legislation eliminated modified community rating in the state's small group market and allows health insurance carriers to medically underwrite groups by plus or minus 25 percent, as recommended by the NAIC's model small group reform legislation. The new law also allows carriers to vary rates according age by a 4 to 1 margin (meaning that the highest rate adjusted for age can be no more than four times greater than the lowest rate charged). Furthermore, it allows rate variations for industry and group size of 20 percent, as well as a variation for geography of 15 percent. Since these changes were just enacted at the end of the 2003 legislative session, it is to soon to tell what their direct impact on the New Hampshire health insurance may be. However, health insurance industry groups were actively supportive of the changes in the law, and

have indicated that these changes were just what was needed to make their member carriers interested in returning to New Hampshire's small group health insurance marketplace.

Colorado

For almost 10 years, the Colorado small-group health insurance experienced an exodus of carriers, and in NAHU's view the problem could be traced primarily to two significant factors—the use of modified community rating for products sold in that market, and the existence of one-life employer groups. Carriers in Colorado only were allowed to adjust rates based on the limited factors of age, geographic location and family composition. As such, carriers in this market had no means of underwriting products based on health status, which caused rates in the state to skyrocket.

Furthermore, the Colorado small-group market is plagued by adverse selection. This is due in part to the fact that the state allows business groups of one to purchase guaranteed issue group coverage. The volume of claims associated with one-life groups is significantly higher than with larger groups where there is more spreading of risk. Furthermore, one-life groups in Colorado tend to purchase coverage on an episodic basis, with the average contract length being only nine months. Other factors contributing to adverse selection in the small-employer market are ironically the state's competitive individual market and unique state laws that make it relatively easy for even very small healthy groups to self-fund, and therefore qualify for exemption from state mandates as rating laws, as provided by ERISA.

The end result of all of these problems is that in 1994, before rate reforms were instituted in Colorado, 83 carriers marketed health insurance in the state. Currently, the small-group health insurance market in the state is actively served by only 12 carriers, with only four carriers actively marketing coverage in the vast rural portions of the state.

However, at the end of the 2003 legislative session, Colorado lawmakers took an important step towards improving their state's small group health insurance market. Legislation was enacted that, among other things, allows health insurers to vary small group market rates based on health status, smoking status, claims experience and industry classification. Beginning September 1, 2003 small-group premiums may be discounted below the indexed rate by up to 15 percent based on those criteria, and effective September 30, 2004, the rates may vary by up to 10 percent above the index rate and 25 percent below it based on the criteria. The reform measure does not address the problem of one-life groups in the state, but it will allow small group carriers to more accurately assess risk and price products more appropriately. So far, no new carriers have reentered the Colorado small-group health insurance market, but several have expressed an interest in doing so by September 30, 2004, when the rating legislation goes into complete effect.

Conclusion

As a professional association of benefit specialists, NAHU members occupy a unique role in the health insurance marketplace. On a daily basis, our membership works with both individual and corporate health insurance consumers to help provide them with the

type of coverage that best serves their individual needs. As such, NAHU members have an excellent understanding of what kinds of health insurance markets best serve consumers effectively. And after years of researching state health insurance markets nationally, NAHU has found time and time again that states that create perverse incentives for individuals to forgo health insurance coverage while driving up the cost of insurance for those who maintain it through anti-market "reforms" like guaranteed issue, mandates or community rating, have only exacerbated the growing problem of the uninsured. Conversely, states that have implemented market-friendly measures, such as high-risk pools, "file and use" laws, and measures that do not hinder the development of extensive health plan networks, have higher degrees of health plan competition, more consumer plan choices, lower health insurance rates and a lower number of uninsured. NAHU urges all states to implement the market-friendly reforms discussed in this paper, and we look forward to working with state and federal-level policymakers to ensure that our goals of reducing the number of uninsured and ensuring vibrant and competitive health insurance markets in all states are achieved.

Summary of Testimony
Senate Health, Education and Social Services Committee
February 22, 2006
Opposition to SB299

Colleen Savoie
Vice President
Willis of Alaska

I provide consulting services to a wide variety of health plans, including smaller insured plans and large self-funded entities. We oppose the any willing provider (AWP) legislation in SB299. In the interest of time, I want to address several of the issues brought up earlier.

- Health plans in Alaska and across the country are struggling with the cost of providing benefits to their employees. **In response to rising costs, employers are forced to make tough choices: reduce benefits, increase employee contribution rates or cost share, or eliminate benefits altogether.**
- One effective method health plans use to help control costs without reducing benefits is to negotiate preferred provider (PPO) agreements with hospitals, physicians, pharmacies and other health care providers.
- Limited PPO networks are successful because:
  - The provider is willing to substantially discount fees, in order to increase their patient volume.
  - The health plan agrees to provide a financial incentive for participants to use the preferred providers.
  - By establishing a mutually beneficial relationship with a network of providers, the providers & health plan work together to positively impact patient service and quality
- **Without the ability to contract with preferred providers and control the provider network, costs will increase.**
  - A study published by Michael Vita in the Journal of Health Economics in 2001 found that health expenditures are higher when AWP laws are enacted.
  - We have first-hand experience with preferred provider negotiations. For example, we participated in a competitive bid process for Anchorage hospital services. Both hospitals were willing to give significant discounts, as long as the plan agreed to contract with one facility and implement financial incentives to use their hospital. They would not offer these significant discounts without this "steerage."
- We are not alone in our opposition to AWP legislation.
  - The National Association of Health Underwriters stated in their 2003 Analysis of State-Level Health Insurance Market Reforms that one of the key components to health insurance market stability was the ability of health plans to develop appropriate networks. They identified **AWP legislation as a threat to market stability.**

- The Federal Trade Commission opposes AWP legislation
  - FTC and Dept of Justice Report, Improving Health Care: A Dose of Competition, July 2004, speaks to this problem. I encourage you to review their report
    - They noted that **AWP laws have anticompetitive effects**:
      - Make it less likely to be able to obtain provider discounts
      - Restrict the ability of health insurers or health plans to structure offerings with varying levels of choice – Would actually reduce options available
    - Recognized the cost impact of AWP laws – and how that affects the consumer: premium increases leading to employers forced to make tough choices about limiting or dropping coverage for employees
    - Suggested that **AWP or Freedom of Choice laws are intended to reduce competition between providers, rather than to protect the interests of patients**.

In addition, I questioned why there is no fiscal note for this bill. The State of Alaska Select Benefits plan, which provides benefits to active employees, recently implemented a PPO arrangement with Providence Hospital which includes "steerage" provisions. They projected a significant cost savings for this change. If the ability to control the network is eliminated, the State's plan would no longer enjoy this cost savings. Why is that not disclosed as a fiscal note?

Thank you for your time.

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Regulatory restrictions on selective contracting: an empirical analysis of "any-willing-provider" regulations

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Abstract

"Any-willing-provider" (AWP) laws compel managed care plans to accept any provider willing to accept the plan's terms and conditions, potentially undermining managed care's ability to constrain spending. However, AWP laws potentially respond to inefficient risk-selection by providers of managed care. With risk selection, observed reductions in expenditures in the managed care sector may be offset by increases in the fee-for-service (FFS) sector, with no net decrease. This paper uses panel data on state expenditures to compare per capita spending levels in states with and without AWP laws. The results indicate that expenditures are higher when AWP laws are enacted. Published by Elsevier Science B.V.

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Keywords: Managed care; Regulation; Fee-for-service

1. Introduction

Managed care health insurance plans have grown substantially over the past two decades, to the point where most privately insured Americans now subscribe to such plans.[1] Although the term 'managed care' masks substantial heterogeneity in the nature of the contractual arrangements among providers, subscribers, and insurers, managed care plans as

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[1] According to the American Association of Health Plans 1999 Fact Sheet, HMO enrollment grew from 34.7 million in 1990 to 78.8 million in 1998. For PPOs, the comparable figures are 38.1 and 89.1 million. This represents about 88% of all privately insured Americans (Census, http://www.census.gov/hhes/hlthins/hlthin98/hi98tl.html).

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conventionally defined almost always provide enrollees with some financial incentive to obtain health care services from a limited panel of providers.

Notwithstanding, the rapid growth of selective contracting, this practice appears to have proven unpopular with at least some subscribers (who would prefer fewer restrictions on provider choice) and some providers (who suffer financially when they are not included in managed care provider networks). This discontent has precipitated the enactment of regulations that would limit the ability of insurers to contract selectively. Enacted in numerous states, and proposed in many more, these laws fall into two related categories. "any-willing-provider" (AWP) laws, which compel managed care plans to accept into their networks any qualified provider who is willing to accept the plan's terms and conditions; and 'freedom of choice' (FOC) laws, which obligate plans to reimburse for care obtained from a qualified provider even if the provider is not a member of the network.[2] By one count, 34 states had enacted some form of FOC or AWP law by 1996.[3]

Holding constant managed cares' market share, it is seemingly self-evident that AWP/FOC laws must increase health expenditures, since they appear to undermine a principal instrument by which managed care entities constrain health care spending, and more generally, because they constrain presumptively beneficial voluntary contracting among providers, subscribers, and insurers. It is possible, however, to rationalize AWP/FOC laws as a welfare-improving response to inefficient risk-selection by managed care insurers, a phenomenon that, if uncorrected, could actually increase expenditures in the fee-for-service (FFS) sector.

There currently is little empirical evidence on the effects of AWP and FOC regulations.[4] In this note, I attempt to assess the impact of AWP/FOC laws on annual state-level health care expenditures data, a task that is complicated by the possible endogeneity of the managed care penetration level. I find some evidence that highly restrictive AWP laws are associated with higher health care expenditure levels. Some caution is warranted in interpreting these results, however, as I also find some evidence indicating that managed care penetration levels and expenditure levels are determined simultaneously.

2. Restrictions on managed care: background

The conventional explanation for the replacement of traditional FFS health insurance plans by managed care institutions is well known, and thus, does not require extensive discussion.[5] The traditional FFS (or indemnity) policy reimbursed providers retrospectively on the basis of incurred expenditures, thereby, inducing moral hazard, i.e. physicians prescribe, and consumers purchase, medical services that would not have been purchased were consumers expected to bear the full cost of the treatment. By integrating the health insurance and health care production functions, and linking physician compensation to the

[2] There are also 'direct access laws', which guarantee that managed care subscribers can seek care directly from specialists without a referral from a primary care provider, without losing benefits. Although 11 states now have such laws, they are all of very recent vintage (i.e. 1994 and 1995).

[3] Ohsfeldt et al. (1998, appendix).

[4] A recent review article found that the only evidence on the impact of AWP laws comes from a handful of studies conducted by consulting firms on behalf of large managed care organizations. See Hellinger (1995).

[5] A more thorough analysis is provided in Cutler and Zeckhauser (2000).

Health Maintenance Organizaton's (HMO) financial performance, this moral hazard can be attenuated, thereby, reducing the plan's per capita expenditures.[6]

If HMOs, PPOs, and other managed care organizations successfully address the moral hazard problems inherent in traditional FFS plans, they not only will induce efficient choices by their own providers and subscribers, but potentially in FFS plans as well. This is because of the simple logic of market competition: the loss of market share and profits to managed care entities may compel traditional FFS plans to offer subscribers (or their employers) comparable premium reductions. This will be especially true in market settings where competition among incumbent FFS plans was sufficiently imperfect to allow them to earn rents. Thus, an increase in managed care market share might be expected to lead to (per capita) expenditure (and, therefore, premium) reductions in both the managed care and FFS sectors. Baker and Corts (1996, 1999) call this the 'market discipline' effect.

Although most analyses of managed care have focused on its ability to (efficiently) constrain expenditures through mitigation of moral hazard, several recent contributions have focused on a less desirable consequence, which Baker and Corts term the 'market segmentation' effect. This effect derives from the susceptibility of insurance markets to adverse selection—consumers who expect to be in relatively poor health will tend to prefer health care plans offering generous benefits, while the relatively healthy will have less demand for broad coverage. Since insurers cannot easily identify the riskiness of prospective enrollees ex ante and charge them different premiums to reflect this risk, they might attempt to charge a premium reflecting average risk. But this premium structure would tend to disproportionately attract unhealthy consumers into the generous plan, necessitating further premium increases.[7]

The existence of unobservable heterogeneous risks gives insurers an incentive to identify high risk enrollees, and to price the policy to reflect this risk (when such pricing is possible), and to discourage enrollment when it is not.[8] Some observers (Newhouse, 1996) have suggested that selectively contracting only with those providers who choose to treat a relatively healthy patient mix is one means by which insurers accomplish the latter. It is this behavior that provides an efficiency rationale for AWP laws. If selective contracting is primarily a mechanism by which insurers undertake privately profitable, but socially inefficient risk selection, policies that restrict their ability to contract selectively might reduce this efficiency loss.

If this selection phenomenon is empirically important, the efficiency gains frequently attributed to managed care are overstated. Premium and expenditure reductions in the managed care sector would be offset, at least partially, by increases in the FFS sector. A number of studies have examined the impact of managed care on conventional FFS expenditures and premiums. The evidence does not clearly favor either of the two competing

[6] In addition to the cost and expenditure reductions obtained through attenuation of subscriber and provider moral hazard, the selective contracting aspect of managed care creates efficiencies because the lower administrative and monitoring costs associated with a smaller provider network. Administrative expenses account for approximately 15% of insurance premiums (Cutler and Zeckhauser, 2000, p. 590). The ability to reduce these expenses substantially, therefore, may also constitute a non-trivial source of economic efficiency from limited provider panels.

[7] This can create what Cutler and Zeckhauser (2000, p. 616) term an adverse selection 'death spiral'. This phenomenon arises when there is no equilibrium in which the most generous plan survives.

[8] See Feldman and Dowd (2000) for a general discussion.

hypotheses. Some studies (e.g. Cutler and Sheiner, 1998; Gaskin and Hadley, 1997; Baker, 1997; Zwanziger and Melnick, 1988) found that increases in managed care market shares led to reductions in FFS expenditure levels and/or rates of growth, a result consistent with the 'market discipline' effect. Other studies, however (e.g. Baker and Corts, 1996, 1999; Feldman et al., 1993; McLaughlin, 1987), found that managed care market share growth can lead to higher FFS premiums, a finding consistent with the 'market segmentation' hypothesis.

3. Empirically testing the impact of AWP and FOC regulations

3.1. Model specification

In this section, I assess the effects of AWP and FOC laws on various measures of health expenditures.[9] The basic test of the impact of AWP laws proposed here exploits state-level information on per capita health care expenditures provided by the Health Care Financing Administration (HCFA). HCFA has constructed annual estimates (for 1980–1998) of total health care spending in each state.[10] These expenditure estimates are disaggregated further by expenditure category (e.g. hospital care, physician care). The empirical specification used here is an adaptation of the framework used in Cutler and Sheiner (1998) and Baker (1997). In those papers, various measures of per capita expenditures are regressed on a measure of managed care market share and a set of control variables. I employ a similar specification, modifying it to include variables indicating the presence of AWP/FOC regulations:

$$e_{it} = \alpha_0 + \beta_1 \times \text{HMOSHARE} + \beta_2 \times \text{AWP} + \sum_{i=1}^{N} \gamma_i \times \text{STATE}_i + \delta \times \text{TREND} + \varphi' X_{it} + \varepsilon_{it} \quad (1)$$

where e_{it} equals real per capita health care expenditures (or some individual component of total expenditures, such as hospital expenditures) in state i and year t; HMOSHARE is the HMO market share (estimates of PPO enrollment are not available);[11] AWP is a dummy

[9] There is a paucity of empirical information on the effects of these regulations. These studies are Lewin-VHI (1995); Wyatt (1991); Atkinson (1994). The Atkinson study is an update of the Wyatt study. The Atkinson and Wyatt studies are simulation studies based on proprietary models of managed care providers. The Lewin-VHI study is a regression analysis which estimates the impact of AWP laws on HMO market share, and the impact of HMO market share on per capita health care expenditures.

[10] The expenditure data are described in Levit et al. (1995). A possible drawback associated with the HCFA state expenditure data is that they are based on revenue received by providers, rather than benefits received by residents (Basu et al., 1995). To the extent there is substantial border crossing by consumers of health care, per capita expenditures calculated on 'revenues received' and 'benefits received' bases could differ. HCFA carried out border crossing adjustments for 1991, which appear to have a relatively minor impact on estimated per capita expenditures on physician services and inpatient hospital services (about 1.80 and 0.98%, respectively). For the purposes of this paper, I assume that the 1991 adjustment factors apply to other years as well, and I adjust the data accordingly.

[11] This variable was obtained from InterStudy, which estimates (as of July of each year) HMO enrollment. These estimates have been used in most other studies of managed care, such as Cutler and Sheiner (1998) and Gaskin and Hadley (1997).

variable indicating the presence or absence of an AWP law; $STATE_i$ are state dummy variables;[12] TREND is a linear time trend; and X_{it} is a vector of other control variables related to health care expenditures (e.g. age, race, income, education).

In the basic specification presented above, the effect of AWP laws is captured by the coefficient on a single dummy variable. This representation is too simplistic, as it fails to capture the heterogeneity observed in actual AWP laws. Marsteller et al. (1997, p. 1135) note that none of the existing quantitative studies differentiates among existing AWP or FOC laws in terms of the strength of the restriction. As they note, this is a potentially a serious drawback, since an AWP/FOC law 'can either greatly interfere with regular plan operations or have little effect in practice' (Marsteller et al., 1997, p. 1140). Restrictions on selective contracting can vary across a number of dimensions. First, some laws apply to some classes of health plans (e.g. PPOs) but not others (e.g. HMOs).[13] Second, some laws make it extremely difficult to terminate providers, while in others termination is easy. Third, some laws affect virtually all providers, while others apply to only certain specific categories of providers.[14]

To reflect this heterogeneity in the strength of AWP restrictions, I adopt a classification scheme derived from the descriptive information contained in Marsteller et al. (1997). Marsteller et al. (1997) rank existing AWP/FOC laws ('weak'; 'weak-to-medium'; 'medium-to-strong'; 'strong'), according to three criterias: (1) entities regulated (e.g. all health plans, or just some small subset); (2) range of providers covered and (3) stringency (e.g. do deselected providers have a grievance procedure?).[15] From this classification scheme, I create two measures of AWP strength: 'weak/moderate', equal to 1 if the regulation falls into the 'weak', 'weak-to-medium', or 'medium-to-strong' categories; and 'strong', equal to 1 if the regulation is classified as 'strong'.

A second issue involves the endogeneity of the managed care share and AWP variables. Basic reasoning suggests that managed care penetration is unlikely to be exogenous with respect to expenditure levels; the greatest opportunities for managed care growth are likely to arise when utilization levels are relatively high, a conjecture that has found empirical support in several earlier studies.[16] Similarly, AWP laws might be more likely to be enacted where

[12] Including the state dummies may help control for some of the simultaneity between managed care share and expenditures, as it has been hypothesized (Cutler and Sheiner, 1998) that HMO growth during the 1980s and 1990s was greatest in states with the highest initial levels of per capita spending. The effects of any such cross-sectional differences will be captured in the coefficients on the state dummy variables.

[13] It is important to note that no AWP or FOC law applies to self-insured employee benefit plan because the Employment Retirement Security Act of 1974 (ERISA) prevents states from regulating any employee health plan. Additionally, the Health Maintenance Organizaton Act of 1973 (HMO Act) also preempts certain categories of laws that would restrict the growth of HMOs (Marsteller et al., 1997, p. 1145).

[14] Arkansas's AWP law, for example, applies to a very large class of providers (including physicians, hospitals, osteopaths, podiatrists, pharmacists, long-term care facilities, among many others) and all types of insurance networks (except of course those that are exempted by ERISA), and provides grievance procedures for deselected providers (Marsteller et al., 1997, p. 1140). A much weaker plan is Utah's, which appears to allow plans to impose limitations based on 'reasonable' selection criteria, which include 'substantial objective and economic grounds, or expected use of particular services based upon prior provider–patient profiles' (Marsteller et al., 1997, p. 1141).

[15] For a more detailed discussion, see Marsteller et al. (1997), Table 2.

[16] See, e.g. Welch (1994) and Porell and Wallack (1990).

growth in HMO share has had a substantial impact on provider welfare. This suggests that expenditures, HMO share, and presence of AWP laws might be determined simultaneously. If so, ordinary least squares estimates of Eq. (1) will yield biased and inconsistent parameter estimates. The standard approach to addressing this would be to employ instrumental variables; however, it is highly questionable whether suitable instruments are available here.[17] Rather than attempting to justify the use of invalid instruments, I attempt instead to assess through indirect means whether endogeneity of these variables is likely to be a problem here.

The empirical implementation of Eq. (1) also includes a number of other exogenous determinants of health care expenditures found in previous studies (e.g. McLaughlin, 1987; Baker, 1997; Baker and Corts, 1999) to vary systematically with health care expenditures. These include: percentage of the population aged 65 and up; population growth rate; percentage of the population black; percentage of the population with bachelor's degrees or better; the unemployment rate; real per capita income; the HCFA wage index; and the percentages of total employment in the following categories: government, agriculture, construction, manufacturing, transportation and public utilities, retail trade, and wholesale trade.

3.2. Parameter estimates

The parameters of Eq. (1) are estimated using state-level annual data for the 1983–1997 period using a generalized least squares procedure that corrects for first order autocorrelation.[18] Table 2 presents a series of regression results, corresponding to three different dependent variables, all calculated on a per capita basis: real total health care expenditures; real total physician services expenditures; and real total hospital care expenditures.[19] I estimate first a model (see Table 2, panel (A), columns (1)–(3)) in which expenditures are a simple additive function of the controls (see Table 1 for a complete list), HMO share, the two AWP regulatory dummy variables, state fixed effects, and a single linear time trend.[20] The coefficients from this model specification suggest that while one cannot reject the null hypothesis that 'weak' or 'moderate' (WEAK) AWP laws have no effect on health care expenditure levels, 'strong' (STRONG) laws are associated with substantially higher total spending levels (see column (1)), a result that is significant at the $p = 0.05$ level. Both the hospital (column (2)) and the physician (column (3)) components of total spending are also substantially higher in the presence of 'strong' AWP laws, although only the former result is significant ($p = 0.10$) at conventional levels of significance.

[17] A few recent studies (Baker, 1997; Baker and Corts, 1999) of the relationship between managed care penetration and expenditures have attempted to develop instruments for managed care penetration, but the plausibility of these instruments is dubious. And as Bound et al. (1995) have shown, estimates derived using poor instruments may perform worse than OLS.

[18] The estimation procedure assumes a common autocorrelation coefficient across states.

[19] As Cutler and Sheiner (1998, p. 79) found, managed care might shift expenditures from one category to another (e.g. procedures might be shifted from hospitals to physicians' offices).

[20] For brevity, I show only the coefficients on the AWP and HMO variables. The full set of coefficient estimates is available upon request.

Table 1
Descriptive statistics

	Description	Mean	Minimum	Maximum
WEAK	State has weak AWP/FOC law	0.06	0	1
STRONG	State has strong AWP/FOC law	0.048	0	1
HMOSHARE	HMO penetration rate	10.68	0	49.33
Pchealth	Per capita total health expenditure	2917.03	1528.06	4616.94
Pchosp	Per capita hospital expenditure	1211.81	660.15	1814.14
Pcmd	Per capita MD expenditure	809.03	337.75	1310.46
Pcrx	Per capita Rx expenditure	115.74	49.48	239.17
Black (%)	Proportion population black	9.6	0.24	36.38
65%+	Proportion population 65+	12.29	2.91	18.56
BA_degree (%)	Proportion population BA degree	20.84	11.1	33.5
Govt_employee (%)	Proportion workforce government	17.58	0	31.31
Agric_employee (%)	Proportion workforce agriculture	1.03	0	6.60
Const_employee (%)	Proportion workforce construction	4.75	0	9.71
Manu_employee (%)	Proportion workforce manufacturing	16.99	3.1	32.91
Trans_employee (%)	Proportion workforce transportation/ public utility	5.23	2.37	9.4
Ret_employee (%)	Proportion workforce retail trade	18.61	3.6	22.9
Ws_employee (%)	Proportion workforce wholesale trade	5.43	3.2	11.52
Unemploy_rate	Unemployment rate	6.21	2.2	18
Income	Real per capita income	22032.53	13629.16	36827.5
Wage_index	HCFA wage index	8608.92	6577	14878
Growth	Population growth rate	0.009	−0.39	0.09
Density	Population density	165.87	0.86	1085.62

Columns (4)–(6) of Table 2, panel (A), relax the assumption of a single linear time trend, and instead allow for state-specific time trends.[21] The resulting coefficient estimates continue to indicate that 'strong' AWP laws are associated with increased levels of total health spending, although the magnitude of this effect (US$ 38 versus 52), and its significance level ($p = 0.10$), are smaller compared to the results obtained with a common trend. The bigger changes occur in the hospital and physician expenditure equations (columns (5) and (6)). Here, the coefficient on STRONG in the hospital equation falls substantially (from US$ 25–14), as does its significance level (from $p = 0.09$–0.31). By contrast, the coefficient on STRONG in the physician services equation increases considerably (from US$ 17–23), and is now statistically significant ($p = 0.08$). This result is consistent with anecdotal evidence that the principal constituency for AWP laws are physicians, not hospital owners.[22] When AWP laws are enacted, the results in column (6) suggests the primary beneficiaries may be high cost physicians who are admitted into what otherwise would be lower cost physician networks.

The estimates in Table 2, panel (A) also suggest, consistent with earlier research (Cutler and Sheiner, 1998; Baker, 1997), that HMO share growth is associated with

[21] We reject the null hypothesis of a common trend at the $p < 0.001$ significance level.

[22] See, e.g. 'Florida Effort Would Let More Doctors Into Managed Care', Business Insurance, 23 September 1996, p. 30.

Table 2
Per capita expenditure equations and annual data, 1983–1997 (t-statistics in parentheses)[a]

	Total health expenditures[b] (1)	Hospital expenditures[b] (2)	Physician expenditures[b] (3)	Total health expenditures[c] (4)	Hospital expenditures[c] (5)	Physician expenditures[c] (6)
(A) Includes HMO share						
WEAK	2.68 (0.19)	5.98 (0.74)	−7.77 (−1.06)	−14.19 (1.22)	−7.13 (−0.96)	−9.82 (−1.42)
STRONG	52.39* (2.07)	24.80+ (1.70)	16.93 (1.29)	38.62+ (1.79)	14.18 (1.02)	22.81+ (1.77)
HMOSHARE	−3.80** (−4.23)	−3.18** (−6.14)	−0.83 (−1.78)	−4.51** (−5.91)	−3.31** (−6.84)	−1.35** (−2.97)
(B) Excludes HMO share						
WEAK	5.12 (−0.36)	7.74 (0.94)	−7.11 (−0.97)	−10.79 (−0.94)	−4.43 (−0.60)	−9.09 (−1.31)
STRONG	49.73* (1.96)	22.14 (1.49)	16.59 (1.26)	32.57 (1.54)	9.88 (−0.72)	21.11+ (1.64)

[a] Parameters estimated with GLS procedure assuming common autocorrelation coefficient across panels. Sample size: $N = 50$, $T = 15$. Other control variables: black (%), 65+ (%); BA_degree (%); government_employee (%); agric_employee (%); const_employee (%); manu_employee (%); trans_employee (%); ret_employee (%); ws_employee (%); unemploy_rate; income; wage_index; growth; density.

[b] Includes state fixed effects and common time trend.

[c] Includes state fixed effects and state-level time trends.

+ Significant at $p < 0.10$.

* Significant at $p < 0.05$.

** Significant at $p < 0.01$.

economically and statistically significant reductions in total health care expenditures.[23] These estimates are generated under the maintained hypothesis that managed care share is exogenous, notwithstanding the possible invalidity of this assumption. For example, as Cutler and Sheiner (1998) argue, it is plausible that managed care growth rates were highest in those states where initial expenditure levels were highest. Indeed, similar arguments could be made about AWP regulations—for example, it is plausible that the presence of these laws might be determined in part by a state's recent experiences with health care expenditures.

The natural approach to addressing possible endogeneity problems would be to use instrumental variables, provided suitable instruments could be found.[24] It is difficult, however, to conceive of variables that plausibly are determinants of HMO membership or AWP laws, but not health care spending behavior.[25] Because of this difficulty in obtaining defensible instruments, it is important to attempt to assess the severity of any simultaneity bias through some alternative means.

As a first pass at this, I simply re-estimate Eq. (1) using the original additive specification (i.e. the specification used in Table 2, panel (A)), but omitting the managed care share variable. These estimates are presented in Table 2, panel (B). As in panel (A), these regressions are estimated with both a common trend and with state-specific trends. Comparing the results contained in panel (B) with those in panel (A), one sees that although the omission of the managed care variable reduces slightly both the economic and statistical significance of the estimated coefficients on STRONG, the basic effect is fairly robust to this change in specification. In particular, the coefficient on STRONG is positive in both physician expenditure regressions; it is statistically significant ($p = 0.10$) in the regression with state-level time trends.

An alternative approach is provided by Gruber and Hanratty (1995) and Friedberg (1998). Here, I create dummy variables set equal to 1 in the year preceding enactment of a 'weak' or 'strong' AWP law. If the direction of causation in the AWP-expenditure relationship is from the former to the latter, then the coefficient on the lead variable should equal zero. If high levels of expenditures prompt the enactment of AWP laws, then the lead term coefficient should be positive. I also include in this equation a lead term for HMOSHARE. If, as seems possible, high expenditure current levels lead to high (future) managed care penetration, we

[23] Although previous research appears to have established that managed care is associated with lower health care expenditures, not all of these studies are clear about the mechanism by which these reductions are achieved. As noted by Cutler and Sheiner (1998, pp. 82–83), managed care programs can curtail expenditures either through 'one-time' reductions—for example, reductions in the fees paid to physicians, or reductions in hospital lengths-of-stay — or through 'ongoing' reductions—related, for example, to the rate at which new medical care technologies are adopted (see Baker and Phibbs, 2000; Baker, 2000). Conceivably, the success of managed care in states such as California reflects 'one-time' reductions that cannot be sustained. If so, presumably this would imply that any attenuation of managed cares' ability to reduce expenditures brought about by AWP policies is also of a one-time nature. To differentiate between these possibilities, I estimate a version of Eq. (1) in which the dependent variables are defined as the annual growth rate of real per capita expenditures (i.e. $\log(e_{it}/e_{it-1})$). The resulting parameter estimates (available upon request) suggest that the expenditure-increasing effects of strong AWP laws may be of a one-time nature, although it must be noted that most of these 'strong' laws are of a fairly recent vintage, and there may be insufficient data points to accurately estimate any effects the laws might have on expenditure trends.

[24] See, e.g. Baker and Corts (1999) for such an attempt.

[25] As Bound et al. (1995) show, using poor instruments can be a worse estimation strategy than using no instruments.

Table 3
Per capita expenditure equations and annual data, 1983–1996 with lead terms for AWP laws and HMO share (t-statistics in parentheses)[a]

	Total health expenditures[b] (1)	Hospital expenditures[b] (2)	Physician expenditures[b] (3)	Total health expenditures[c] (4)	Hospital expenditures[c] (5)	Physician expenditures[c] (6)
WEAK	15.33 (0.81)	14.55 (1.36)	−10.20 (−1.01)	−11.10 (−0.68)	−1.09 (−0.11)	−12.62 (−1.27)
WEAK(+1)	14.72 (1.05)	9.62 (1.21)	−0.96 (−0.13)	2.45 (−0.20)	3.05 (0.42)	−3.23 (−0.45)
STRONG	51.45 (1.57)	33.32[+] (1.80)	4.94 (0.28)	36.04 (1.20)	13.19 (0.73)	20.25 (1.11)
STRONG(+1)	2.01 (0.08)	9.33 (0.67)	−10.40 (−0.78)	−8.38 (−0.38)	−0.68 (−0.05)	−6.40 (−0.48)
HMOSHARE	−3.64[**] (−3.49)	−2.96[**] (−4.99)	−0.82 (−1.45)	−4.79[**] (−5.33)	−2.92[**] (−5.40)	−1.84[**] (−3.37)
HMOSHARE(+1)	−3.18[**] (−3.49)	−2.54[**] (−4.90)	−1.08[*] (−2.18)	−4.41[**] (−5.57)	−2.97[**] (−6.24)	−1.81[**] (−3.77)

[a] Parameters estimated with GLS procedure assuming common autocorrelation coefficient across panels. Sample size: $N = 50$, $T = 14$. Other control variables: black (%); 65+ (%); BA_degree (%); government_employee (%); agric_employee (%); const_employee (%); manu_employee (%); trans_employee (%); ret_employee (%); ws_employee (%); unemploy_rate; income; wage_index; growth; density.

[b] Includes state fixed effects and common time trend.

[c] Includes state fixed effects and state-level time trends.

[+] Significant at $p < 0.10$.

[*] Significant at $p < 0.05$.

[**] Significant at $p < 0.01$.